

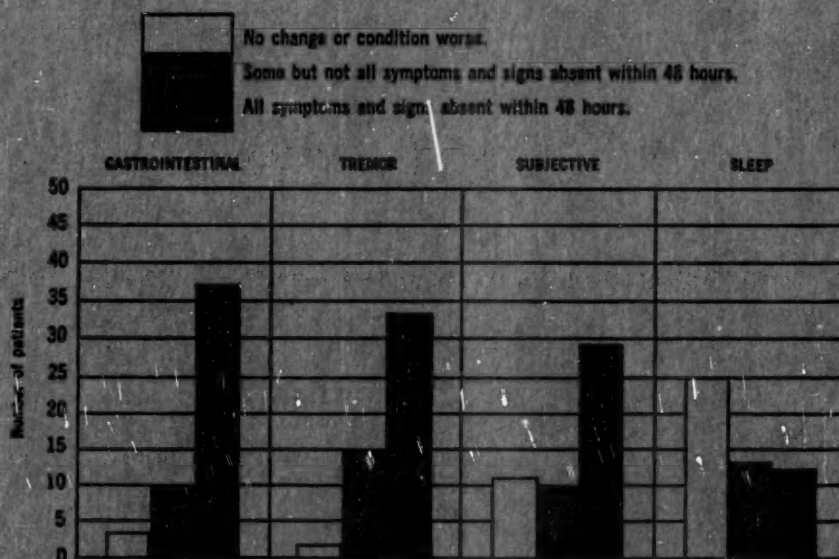
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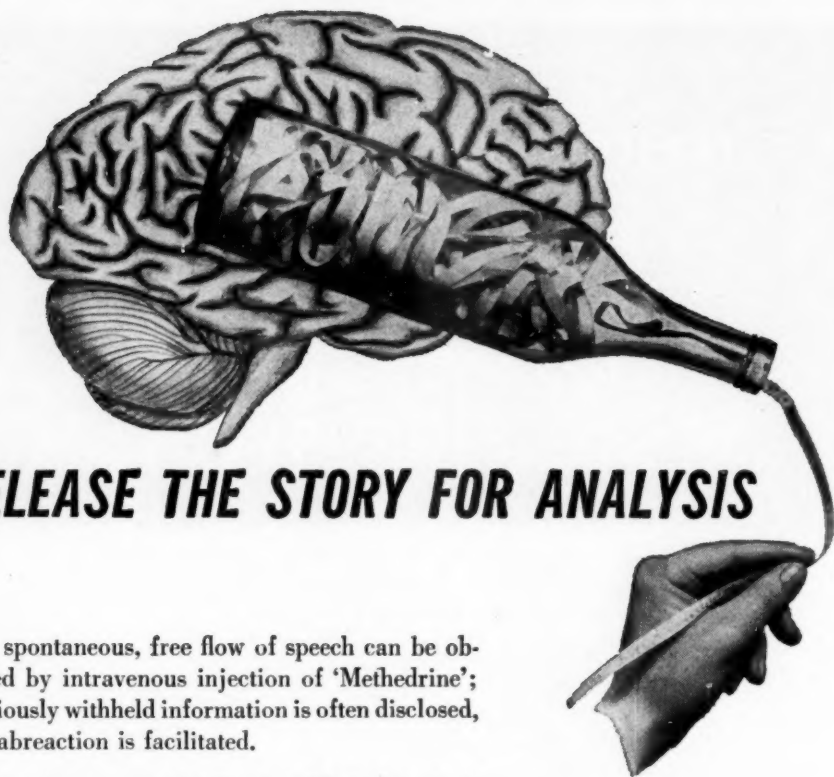
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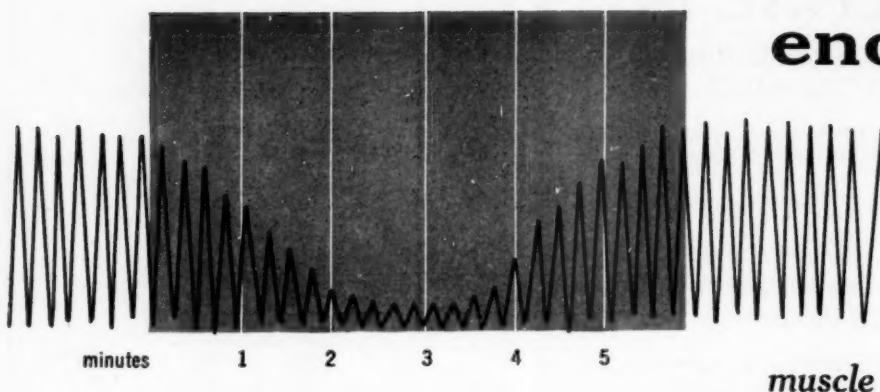
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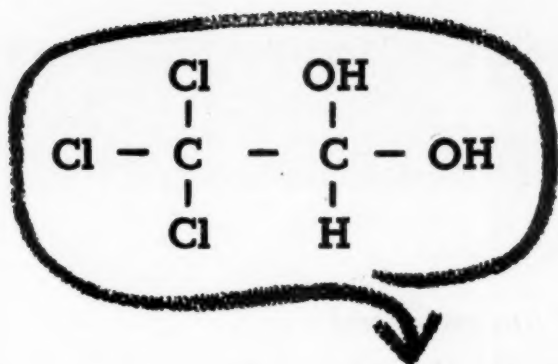
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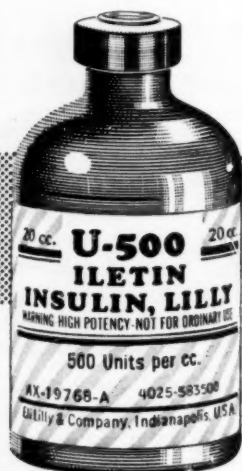
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It is my privilege, as your President, to deliver to you this annual address. A year ago you bestowed upon me the honor of this great office; and, through the succeeding twelve-month, you have given force and reality to that trust, through the wisdom of the Council, the energy of the standing committees, the loyalty of the district branches and affiliate societies and the zeal and enthusiasm of the staff of the Association. For all of this I thank you.

Last May, speaking before you, I commented upon the opportunity afforded the President of The American Psychiatric Association to view—and, in a measure, to participate in—the vast, farflung building of psychiatry and to report to you on happenings that have greatly moved his mind or heart; to view the incessant search for facts, the forging of theories, the raising of buildings, the founding of laboratories and the marshaling of men—all to the end that we, together with our fellows from every field of human endeavor, may join our skills, our powers, our hopes in the newly forming world of thought and action.

During this past year, our work in this great endeavor has gone on apace. New societies have been formed, wider territories have been opened up, and powerful affiliations have been joined. Ideas for next year's harvesting have been sowed and fresh enterprises set in motion, to gather strength with coming years. All this is a matter of record in our journals and bulletins, in innumerable reports from committees and commissions, from boards and councils, district branches and affiliate societies, from Association offices and from your officers. No one man could record the complexity, the detail, the significances of these hurrying events.

Your Presidents—each in his hour—have talked to you about some crucial issue of the work we men and women are engaged upon

as psychiatrists. And in more settled days, this was most fitting.

The nature of our times has persuaded me to break with that custom and to talk to you, rather, of the part that we psychiatrists are called upon to play as citizens. For there is a need to state for ourselves a set of premises reaching far beyond our scientific work—a set of premises (or philosophy of conduct, if you will) that shall enable us befittingly to fulfill our responsibilities as citizens during this age of transition.

By profession, each of us is a psychiatrist. In ourselves, we are men and women seeking to find a significance in our times and work. Indeed, the very nature of our work makes it more necessary for us to have a clear, sharp picture of our times and of the part we have to play.

I want to talk to you about the problems of men and women in a world grown watchful and guarded and defensive with respect to all change, lest change be danger and death. I want to talk to you about the problems of men and women engaged in science—which spells change and which, in our field, spells change in human affairs.

I want to talk to you about our problems as men and women intensely devoted to our way of life—and, indeed, through our daily dealings with our fellows, the more directly aware of its great gifts; yet who, in fulfillment of our responsibilities, must point to things that require to be changed for the well-being of all.

Men living in pivotal periods of history have but rarely been fully aware of the sweep and moment of the events of their times. Few of those who marvelled at the first mariner's compass, or who stared at the newly discovered rings of Saturn through rough-and-ready lenses could have known that Western man was about to break out of the territorial limits in which he had lived from the beginning of time and to enter into full possession of his earth. Few of those who saw the first feeble steam engine, or who

¹ Read at the 109th annual meeting of The American Psychiatric Association, Los Angeles, Calif., May 4-8, 1953.

participated in the setting up of the earliest chemical and physics laboratories, saw in these the birth of the partnership between industry and science—a partnership destined not only to put an end to the scarcity that had presided over the thousands of preceding years but also to bring with it an extraordinary number of changes in our society.

But we, who live centered in a network of communications that keeps us in touch more immediate, more sensitive, and more extensive than ever known before with all our fellows everywhere, may well have intimations of the transcending nature of the change that is not only affecting our relations with our material world and our advancement through mechanical invention, but, most basic of all, bringing about a shift in our old conceptions of ourselves—our powers, our destiny—in a word, of our very nature.

From this great shift are being thrown off movements that, though parts, are in themselves of the largest consequence: the growth of humanism, the establishment of the social sciences, and the conception of mental health.

Our premises about man and his relation to his world, which have endured since the end of the Middle Ages, are now under intense scrutiny. Beliefs and customs that had seemed as fixed as ancient assertion held the stars to be, are seen, in the light of modern knowledge, to be no less variable, no less changing, than are those selfsame astral bodies.

This great shift in thought differs from all preceding, in that major inquiry is at last being directed at the ultimate source of conceptions and customs and institutions—namely, man himself. Hence it is that psychiatry has found itself, by virtue of the timing of the historic process, sharing with those other disciplines concerned with human affairs a great responsibility for leadership in this reshaping of our world of thought.

By time and the running tide of events we are brought to this point. Many men, from many fields of human thought, have stood here before us—have stood vested with a measure of responsibility for the ways in which their generation conceived of their nature and of their ends. At this place in time and process, and for a little while to come, we have a share in that leadership.

Each of the Great World Wars has given fresh impetus to the study of human behavior in our western countries, as indeed it has to all the services and sciences that deal with human welfare. There has been a profound and wide realization of the fact that, for any national community to survive the present intense stresses of our times, the mental health and social welfare of its people must be maintained at the highest possible point. We have recognized that the vigor and the initiative and the strength of the people and their morale are intimately related to their mental health.

We have seen in tragic sequence one great national community after another succumb to these tremendous times and, seeking to survive, pass into an authoritarianism of the right or of the left. They succumbed when they had exhausted their social resourcefulness, when the social skills of their people no longer sufficed to find ways of adjusting and adapting to overwhelming pressures. Individual values were progressively abandoned, freedom grew dim, sank, and went out in the night of the mass man.

These selfsame forces beat on us. We have withstood them, though there are many warning signs—the rising fears of the hour, the degrading of inquiry into inquisition, the growing wariness of views and proposals that are new and different.

We have survived because of the strength of our way of life. And no small part of that strength is constituted by the high degree of social skills that our peoples possess and by our traditions of local and community initiative. In the west, we have built upon the belief in the essential value of the individual. We have set before us the never-ending challenge of maintaining societies in which individual freedom and civic responsibility find continually new and constructive answers to the problems of our days.

Hence our peoples have a long history of interest in the fostering of fit and vigorous personalities, and in the ways in which families and communities successfully manage their affairs. Public need and individual interest have joined to bring into existence a great array of personnel highly skilled in human affairs. Compared to those countries that succumbed to communism or fascism, or that

never emerged from the great authoritarianisms of the past, we have an incomparably greater number of vigorous people trained as psychologists and sociologists, as teachers and counselors, as psychiatrists, as industrial personnel and social service workers.

And, of major importance, we have now large numbers of the public and strong lay organizations keenly aware of the supreme value of a commonsense and scientific approach to individual and public affairs.

The changes that have already been brought about during the past half-century in our conception of ourselves, and the resulting shifts in social practices, have been extraordinary.

Together with our colleagues in other disciplines concerned with human nature we have spread to our neighbors everywhere within our communities, as common knowledge, what we now know of the great instinctual drives. That the sexual life has origins in infancy, that resentment and hostility may underlie the most filial of devotion, that acceptance of oneself is a prerequisite to sound relations with others, are all premises that a few decades ago stood in such sharp opposition to the traditional and prevailing beliefs that their now wide acceptance might well have seemed almost impossible.

But in bringing these premises into action in daily life, we have learned that new and more enlightened ways do not inevitably supplant the old and the obsolescent. To set them into action calls for courage and determination and wisdom.

Under the impact of the application of the scientific method to human behavior, there has been hewn out of the dark mass of our ignorance the living form of the concept of human behavior as being meaningful and understandable. From this have sprung endless consequences of great significance.

For if behavior can be understood in terms of what has happened, and is happening, to the individual, then we may reasonably expect to be able to modify action. Hence the great changes in child rearing, the vast expansions of social work, the determination to subordinate punishment to rehabilitation.

And then again, our studies of the growth and the depths of human personality have led to the progressive restating, in terms of health, of matters once previously recognized

as essentially ethical or moral problems. Deviations in sexual behavior, impulsiveness, and antisocial acts are now seen as things not simply to be labelled and condemned, but as problems to be understood and corrected.

All this has led to the growth of a way of thinking about human behavior that constitutes one of the supreme advances of science, but which, because it stands in crucial contrast to ways of thought of a thousand years, creates its own opposition of the hour as well as its gathering host of friends. The idea of human behavior as something to be understood, not simply labelled and condemned or praised accordingly; the idea of human behavior as the outcome of what we have felt and known and done, and not as the unfolding of a preordained destiny; the idea that our behavior, our ways of life, our social institutions are capable, through our own efforts, of being modified to an extent the limits of which are not yet known. This great idea is still new, still grasped only by a few but, nonetheless, is one of the most dynamic of which our long history has record.

Our ways of thinking about human behavior, the great new premises about living that have been built up during the last half-century, express themselves in our hourly decisions and actions—whether we are administrators or instructors, whether we are pioneering in research or immersed in the busy clinical round, whether we are testifying in court, speaking on the radio, writing a book, or attempting to rescue a marriage.

To each and all of us there come occasions that test us, not only in our professional quality but as men and women, as citizens of this age of transition—occasions the more severe and the more searching by reason of the fact that we are living in national communities now beginning to show threatening evidence of the destructive stresses to which they are being subjected by these unparalleled times.

To take issue with entrenched error has never been a matter lightly to be undertaken. The lives and struggles of all those who have made fundamental changes in the thinking of our field are testimony to this. Sigmund Freud, when many of his colleagues fell back before the vistas revealed by the opening up of the instinctive and unconscious life of the individual, persisted. But he revealed in his

letters an intensely human struggle between a desire for academic recognition and acceptance by the little hierarchy of the day and an unceasing urge to follow knowledge wherever it might lead. He chose the latter, to the great good of humanity and to his own imperishable renown.

That selfsame struggle is repeated in the lives of many men and women at work within our field. And, in other lands than ours, our colleagues have been forced by authority to deny their own works and to resort to compromises with their integrity—the destructive nature of which we can only guess.

There is a constant need for such courage; and yet, in this field, courage without wisdom were indeed a danger. We are already unleashing the extraordinary power that exists within the group; we can see, in dim design, some of the ways whereby personality is molded.

Soon—and no man can tell how soon—we shall gain a greater knowledge of the motivation of men and of the molding of personality. History is full of the results of knowledge obtained before we were ready to use it with wisdom. Nothing that has thus far transpired is likely to be more serious than for humanity to learn how to control the development of personality and how to master the forces of group dynamics before we have developed a value system capable of dealing with such a situation.

Yet here, in this system, is an area that more than any other requires that the research psychiatrist proceed with courage and zeal, yet with a wisdom that respects that with which he deals—a wisdom that enables him to deal with the hostility and opposition that he must expect as part of the problem he is seeking to solve.

There is a time for the bold and unyielding stand; there is a place for the slow waiting and patient persistence at the birth of new customs. But our way of dealing with human behavior expresses itself in all of us, whether we are pioneering research men, whether we are clinicians, administrators, or educators.

To each man comes his time of testing; to the administrator struggling with a public or legislative attitude that holds the psychiatric patient to be a thing apart and violently rejects the community of human conflict and problem. Shall he take a stand that will let

the light of publicity in upon barely human conditions in his hospital; or will he, acquiescing in political expediency, consolidate his own position? Can he best serve his patients by going or staying? Each man must answer this question alone. But in doing so, he can align himself with all those who before him have striven so mightily and with such steadily growing success for the expansion of human welfare.

For our field is only a small segment of the immense front upon which the vast surge of humanism has been advancing the values of the individual and man's enhancement of his own ways of life.

Courage, wisdom, and never-ending persistence are essential; but he is moving with a tide far more powerful than the transitory obstruction of some local political boss or reactionary clique.

Wherever the psychiatrist has to deal with matters in which the public interest is emotionally aroused, one can anticipate that his professional powers and his qualities as a citizen may well be called upon in no uncertain manner. Wherever the customs of the community may be infringed, where the mores have been transgressed by some person, no matter how sick, public anxieties and resentments are likely to be deeply stirred. This is more certain to be the case in these days when there is a growing inflexibility of standard, a spreading consolidation of custom, a subtly treacherous xenophobia of ideas. The psychiatrist, summoned to testify on behalf of some individual brought to court because of antisocial behavior that has aroused the insecurities of his community, finds himself in a position that will sharply test his quality.

The psychiatrist concerned with public education is aware that he must lead, that he cannot fulfill his responsibilities to his neighbors if he simply repeats back to his hearers long-accepted, time-honored errors. But how much can be accepted, and in what form? Many things that ultimately became valuable and constructive parts of our common daily living were repeatedly rejected by a social structure not yet ready to incorporate them. If it is true that those who re-echo the dicta of the day do not lead, it is no less true that those so far in advance of their fellows that they lose contact do not lead either.

Those concerned with the teaching of mental health in the schools may well find themselves attempting to teach in the midst of one of the most hotly contested battlegrounds of our times. For there, and in the home, is being decided what are to be the prevalent personality structures of our times. Are ideals of passivity, acceptance, and traditionalism to prevail, or the concepts of aggressive competition and self-assurance? Is the prevalent personality to be that of adaptiveness or aggressiveness? Should creative individualism or conventional conformity take the lead? What room or compromises are there for erroneous but, nonetheless, age-old and therefore perhaps supportive beliefs about guilt, sex, and the right to parenthood?

The early 20th century, with its *laissez-faire*, its people grown to security through half a century free of major wars, is gone. We live in a world where massive displacement and sudden death are strangers to no one, a world in which the continuous safety of the whole depends upon the goodwill of every part, but a world still tragically far from unity.

It would be idle and dangerous folly to believe that the same easy rule of life our fathers followed can sustain us now. Much remains, it is true; but each generation must find its own road to the love of freedom, the tolerance, the equality of opportunity that we cherish as our way of life. For in these last decades we have learned to know the conspiratorial mind; we have learned that the easy, unwatching friendliness of earlier days can be our own undoing.

And here lies the razor edge of our difficulties as men and women of this period, as those who work with human nature.

We find ourselves bound, by the nature of our work, to attempt to change what is damaging to human personality—damaging in belief and custom and practice. When, yielding to our own feelings, we ourselves become mere protagonists, we abandon our position and our usefulness to our fellows as scientists.

As a first rule in our philosophy of conduct, I shall point to our supreme duty to our neighbors, to the imperative with which humanity has charged us: that we should maintain, against all pressures, against all inner fears and outer threats, our way of thinking about human behavior—bright with to-

morrow's sun but fragile before the dismal mountains of our past failures to understand ourselves; that we should maintain it not simply when we are engaged in our professional work but, most especially, when we deal with our friends as citizens and neighbors. This way of thought flowers in an objectivity that the heavy weight and mindless momentum of old custom continually threatens to crush into the ground; it flowers in a willingness to examine and to review, to explore all aspects of the endlessly complex individual and social problems of our times. An objectivity that expresses itself, above all, in an openness of mind, in a determination to recognize tradition and dogma and the emotion-laden cries and countercries of these days for what they are; and yet, at the same time, maintaining a readiness to understand their meaning and their driving force for those around us. An objectivity that is capable of seeing things as they actually are, rather than as they ought to be or should be in terms of the sanctions of our society; and yet remaining capable of understanding the significance of these imperatives for those who accept them.

Of the many gains that we have made in recent years, one of the most important for us to bear in mind, as we gird ourselves to struggle with our times, is our knowledge that hostility and anxiety are both manifold in their expressions and most virulently contagious. We must be unrestingly alert to protect ourselves against such contagion by hostility and anxiety, forces that our long history has shown to have been more destructive of human life than any plague. We must continually remind ourselves—no matter what the pressures, the hatreds we may encounter, the fears we ourselves may experience—that these are part of the problem with which we are dealing. Whenever, yielding to their perilous powers, we are driven out of our ability to view the struggles and the questions of the hour dispassionately and objectively, whenever we are forced to abandon our attempts to explore them by patient study, by the asking of those crucial questions of "how" and "why"—in a word, by using the tools of science—then we have indeed suffered great loss. And our communities, which have brought the social sciences into existence as a means of meeting the crises of the last

three-quarters of a century, can count that selfsame loss a millionfold.

The maintenance of objectivity in the midst of turmoil, the patient seeking for a solution, the never-resting determination to help substitute for ineffective, damaging customs and beliefs those that will lead to a progressive enlightenment, a strengthening of the individual and of his society, is an outstanding contribution that we can make as scientists and citizens in these troubled years. It is part of the contribution that society can expect of us that we should be able the more clear-sightedly to identify the unreasoning and unreasonable in human behavior, whether it is that of the individual or of our community.

We can discredit the absurd and treacherous rumor, we can point to the individual grown fanatical with fear, we can recognize and show to our neighbors where hostilities and deep insecurities of the community are, with senseless rage, being vented on some truly harmless scapegoat. We can act as a fire lane, refusing to allow some billowing gust of community hostility or anxiety to pass through us onto others.

As psychiatrists, we are physicians having an immemorial responsibility for the well-being of our patients. As neighbors in our home towns and as citizens in our national communities we have duties to perform that none but ourselves and our colleagues in the social sciences can undertake: the duty to act as steady points of reference, touchstones of reality in this rising clamor of uncertainty, hostility, and authoritarianism.

If we act faithfully to point to unreasoning fears, to baseless hostilities, and if we seek to the best of our ability to abate them, then we must be no less alert as neighbors and citizens in our communities—both great and small—to bring to bear what powers we have to understand and point to the conspiratorial mind, to those who pervert the great words on which our society is founded, the words of liberty and individual worth.

In doing so, we must remain continually on guard lest, in opposing one tyranny, we ally ourselves unwittingly with another. Our knowledge of human nature, our techniques for the exploration of motive and memory, of defence and of what is hidden, if torn from their framework of professional integrity and proper concern for the individual

and for the community may, their use perverted, become the most deadly weapons yet directed against the dignity and serenity of human life.

In our watchfulness, we can be guided by the fact—supported by all knowledge yet accumulated—that it is only in societies in which the essential values of the person, of his reasonable responsibilities to his neighbors, in which tolerance and the expansion of freedom are the guiding ideas, that the individual can attain his full maturity and stature.

Our first role of conduct, then, is to offer, as citizens and neighbors, what skills we have in the understanding of people. And our primary obligation is to maintain, in these troubled days, the clarity and objectivity of an emerging way of thinking about human problems, of which we and our colleagues in the social sciences are the first pioneers.

Our second rule of conduct is our obligation to be familiar with our times—to seek to know the meaning of this great passage in human affairs. It has been said that in these days the work of the scientist must have relevance; it has been said, again, that the scientist must accept social responsibility, must be cognizant of the consequences of his work.

The public should, then, expect that we be reasonably familiar with the great and stirring changes of the day, that we should be knowledgeable in respect to those events that, in their magnitude, are charging and affecting, almost hour by hour, the lives of our patients and of our neighbors.

To achieve this, we must maintain our sense of history; we must be able to see the great, unfolding events of our times in their perspective. We are in a period of vast shift in our whole world of thought, and the exploding core of all is in our conception of our own nature, of our relations to men and things and events.

These basic premises first appeared during the renaissance of learning and early took the form of insistence upon the individual as the origin of change and action, as a source of power. These new ideas broke away in violent contrast from those of the collectivism and absolutism of the Middle Ages. Rationalism (the belief that reason could enable the individual to solve the problems of the day, to maintain himself as an autonomous and

single unit in society) was a natural consequence.

From these new premises, breathing of freedom and power, there sprang in bold and rapid sequence beliefs in the controllability of nature; men of the West saw themselves freed from the dull, deadening oppression of destiny—and, seeing themselves so, they empowered themselves to act. In long, swift sweeps across these centuries they opened up the earth and the universe beyond; the tremendous interplay between science and the new industrialism was set in motion, and many Victorians felt that they could see, only a short distance ahead, the fulfillment of man's every need and dream.

Of all the immense release of initiative and imagination that this great shift in thinking brought about, by far the greater part has gone to an attack upon our material universe, to the solution of the basic problems of how to get from here to there, how to send a message to a million men across ten thousand miles, how to feed, clothe, and shelter our ever-growing numbers.

But that great enterprise must dim in the shadow cast by the still vaster form now rising before us—the stark, elemental problem of how to live with each other in this new world we have created. The objectives we are now seeking are the immemorial ones of mankind: freedom from anxiety, freedom from our own destructive impulses and those of our neighbor, freedom to express ourselves; freedom for us, for our children, and for our neighbors to grow to full stature as human beings. To the searching eye and the thoughtful mind, many of the conflicts between us are conflicts of means and not of ends. And our abilities, acquired through study, to be perceptive of these deeper meanings can constitute binding forces in these disruptive days.

There are great rifts in our cultural premises. We are well familiar with the social sanction for yielding and compromise, for acceptance and passivity, and the diametrically opposed and widely held sanctions for drive, energy, push and aggressiveness, for independence and vigor.

We are equally aware of the cultural failure to recognize the essential ambivalence of many of our relations with each other; that hate and love do quite normally exist with respect to the same person. We must be sen-

sitively attuned to the vast amount of anxiety and guilt that is created when such rifts occur, when cultural beliefs do not correspond with the basic facts of human nature. And we must be not less alert to the fact that in a period of such rapid change it is to be anticipated that fixation of custom and belief, long past their days of relevance, is common.

Our understanding of our period also demands that we recognize that this is a time of cultural clash, not only in the older sense of the term (as applied to the relations between immigrant and host groups) but now much more pervasively present in the great clashes between value systems, which are only now being appreciated and which are clearly destined to become increasingly meaningful as the facts about the extraordinarily varied cultures that exist around the earth become known and understood by men everywhere.

As citizens of our age we can see that there is going on a great exchange of liberties and responsibilities between the individual and society. The individual has gained an increased freedom from want and has, in turn, suffered the loss of some freedom of initiative. The ultimate effects upon social anxiety and motivation are still unclear, but it is certain that in the countries of the West the old conception of education for work as a means of basic survival is giving place to the conception of education for living.

As citizens of our times also deeply concerned with happenings in other national communities, we can recognize—and pass on our understanding to others—the extraordinary catalytic effects of industrialization, now a primary objective in many newly formed national groups. We can point to the exceptionally rapid and widespread changes that this brings about in the relations of the man to his community, in family life, in the status of women, and in deeply rooted rural customs and beliefs. The hostilities and social insecurities that may arise when these are not understood are a matter of painful record in our own industrial history.

No matter how disturbing the times, how destructive they may seem of human values, the man who can view the long panorama of history must see us still in the full flood of that enormous tide of humanism that set to flowing almost as far back as the Renaissance and has expressed itself, in this last half cen-

tury, in sweeping changes in our social structure—all destined for the well-being and welfare of the individual man and of his neighbors. If we measure and assess our daily acts, our triumphs, and our failures against this vast backdrop of an unfolding historic process, we shall not fail to discern the relevant from the incidental.

As a third rule of conduct, I would press upon you our great need to be whole men. If we are to be points of security and strength and dependence for our neighbors, none of us can afford to be a man divided against himself. And yet, the fact that we are men and women of our age and, at the same time, men and women deeply engaged in the scientific study of human behavior, renders it perhaps the more difficult for us to maintain that inner consistency that must be the basis of strength. As we grew up through our early and our adolescent years in our communities, our personalities drew their structure and their content from the beliefs, the customs, and the age-old traditions of our societies. The way of thinking about human behavior that we learned throughout those years is a way that is immemorably established. And yet it is a way of thinking diametrically opposite, in many important respects, to the way of thought demanded by the scientific approach to human behavior. Many things to which, in our younger years, we gave allegiance as established fact are now seen by us as outworn and ineffective. We have passed, for instance, from the conception of punishment to that of rehabilitation. And yet how many of us, in periods of stress and resentment, are likely to fall back into more primitive approaches when confronted with aggressively deviant human behavior. We grew up with a set of beliefs concerning variations in the expression of the sexual instinct; we grew up with beliefs concerning feelings of guilt, which now, as men and women thinking scientifically about behavior, are no longer tenable. When faced with the pressure of immediate and personal involvement in such problems, it is essential that we should meet them with an inner consistency and that we should not be overwhelmed by the ancient past.

And yet, at the same time, if we are to reach our greatest effectiveness as citizens

and neighbors, it is no less essential that we should feel ourselves in historical continuity with the great ideals and objectives that have moved men from the earliest times. Those ideals and objectives remain unchanged. It is only that our methods of seeking to attain them have undergone the most significant and perhaps the most dynamic alterations of which we have record.

As a fourth rule of conduct, I would give you the never-ending need to be simple in approaching these problems of our times. There can be no doubt that the inquiring mind, attempting to grapple with the enormous complexities of our nature and of these exceptional days, explores and throws up an endless variety of suppositions and conjectures; and that these, too often, become organized in a theoretic superstructure that may give some comfort to the insecure, but that, in truth, constitutes a barrier to thought. One thinks here of the simplicity and yet the power of a mind that could see a great and basic problem in why an apple fell to the ground, and the humility of a mind that, at the end of a life of most outstanding brilliance, could liken itself to a boy playing on an infinite beach and picking up and curiously examining one or two of its endless number of pebbles.

Finally, I would give you an enduring rule to conduct that has guided men everywhere in days of trouble—namely, to follow courage and wisdom. This may seem ancient knowledge, but it is knowledge that must be everlastingly learned afresh by each new division of mankind upon whom devolves the duty and responsibility of mounting our frontier lines and driving forward into that enticing but greatly feared unknown land of new ideas, new ways of life, untried premises, and yet-to-be-formed beliefs.

There are few gifts that we can bring to our neighbors and fellow citizens in these days that are greater than steadfastness of mind—a steadfastness of mind that is not swept by rumor and by fear, not daunted by unjust accusations and does not lose faith in another because of idle and unfounded gossip; a steadfastness of mind that can wait until all the evidence is in before coming to judgment; a steadfastness of mind that is not swayed by the hair-trigger decision, by

the enticements of immediate and explosive action—action simply for the sake of action, without thought and without deliberation.

One thinks of chance meetings of already huddling little groups of men and women—afraid to look, to speak, to act, save in accepted form; afraid to tread off the beaten track; afraid to be different, for difference is danger. One thinks of men at great universities who will not speak out on controversial subjects. And those who will not these days speak out against error and fear and hate may never speak again in freedom's name.

But courage without wisdom is not enough—a wisdom that, despite the pressures that may bear upon us personally, can still discern the long objectives of man's march; a wisdom that will enable us to view the immediate pressures of the hour as part of the problem that we have to solve and not as something that arouses our fears and hostilities, and that, in so arousing, can drive us from carefully constructed and ordered attempts to solve these difficult matters and

leave us running here and there in impotent anger and in fear. We need a steadfastness of mind and a wisdom that will enable us to distinguish reasonable watchfulness from corroding suspicion, to distinguish between proper caution and scrutiny and gossip grown to gale proportions.

For we can be destroyed by our own fears and by the unleashing of our hostilities against ourselves. The responsibilities that rest upon those of us in our field and in the field of our colleagues in other disciplines familiar with human nature are great. If we are successful as scientists and citizens, we shall make a contribution, far greater than our numbers, to the preservation of human values and of a way of life that we and our predecessors have cherished—and they often with their lives. If we fail our neighbors and our fellow citizens now, our failure may in turn make a no less great and unhappy contribution to our passage into the darkness that has overcome so many human communities in this last half century.

D. EWEN CAMERON, M. D.

PRESIDENT, 1952-1953

A BIOGRAPHICAL SKETCH

GREGORY ZILBOORG, M. D., NEW YORK, N. Y.

D. Ewen Cameron is the seventy-ninth president of our Association, which is completing the eleventh decade of its existence. One hundred and ten years is not a long time in the perspective of human history, but on the continent of North America, and with the United States of America as a frame of reference, 11 times 10 years represents about three-fifths of the period that has elapsed since the Declaration of Independence. It has been an important period, fraught with cultural changes, historical upheavals, and many scientific crises. It would have been unthinkable in 1776 to have Canadian psychiatry as part and parcel of American psychiatry; and it would have been impossible to induce Benjamin Rush, although himself a graduate of the University of Edinburgh, to extend his scientific hand across the then newly forming border with the possession of the British Crown.

D. Ewen Cameron is as Scottish as the town, the Bridge of Allan, where he was born on Christmas Eve in 1901. He is also as Canadian as McGill University, where he is now professor of psychiatry, and as American as Baltimore and Worcester, where he served respectively as resident at Phipps Clinic and instructor in psychiatry at Johns Hopkins Hospital (1927-1928), and as resident director of the Research Division of Worcester State Hospital (1937-1938).

Viewed from the point of view of historical synthesis, D. Ewen Cameron rightfully represents the cultural trends and the scientific orientation of both the United States and Canada. It is difficult, of course, to evaluate properly the true historical position of our Association today, and the historical meaning of the presidency and of its occupant today. Contemporaries are poor historians of the present, but the historical sense of a given period may not escape one. I am reminded in this connection of a remark made to me by the late Adolf Meyer while he was President of The American Psychiatric Association. It

was in 1928 (Cameron was then on the resident staff of the Phipps Clinic) at the Hotel Radisson in Minneapolis, where the Association was meeting. In a quiet, almost impassive tone, Meyer said concluding a rather long sentence about psychiatry in general: "Of course, our Association now is scientifically speaking at its lowest ebb." This was Meyer's evaluation at a time when he, the dean and rightful leader of American psychiatry, was himself the President of the Association and Earl D. Bond the Secretary! Modesty it was, to be sure, but it also was a telling illustration of how a contemporary is apt to lack understanding of the historical moment that he himself symbolizes.

Be that as it may, the presidency of D. Ewen Cameron may be viewed from the angle of the historical-scientific perspective at least to some extent and at least with some justification by those to whom history is a part of their scientific pursuits. As a matter of fact, in the case of D. Ewen Cameron this is the approach of choice because, as one of his associates and superiors once designated him, this "young Scotsman Cameron" may even give the impression of remoteness as a person, a little distant and dour, yet simple and almost serene; his is an attitude not of an individualist who seeks to impress his own personal drives on his contemporaries, but rather of a public servant (so typical of the old-fashioned and straightforward Anglo-Saxon) who lives the major trends of his time in unison with and for the community he lives in, without drooping to become a dull conformist, an unoriginal self-disciplined nonentity. Dr. Cameron's cultural and scientific background are excellent guarantors of his individualistic devotion to the community; he might therefore appear at times to be as paradoxical as is this characterization.

Dr. Cameron is only fifty-one now; his scientific task is therefore far from completed, and as a living factor in psychiatric education he is to be with us for years to come. In

other words, the presidency of The American Psychiatric Association is not the pinnacle and culmination of a career, but a high steppingstone only.

Dr. Cameron's development, personal and professional, was steady from the outset: Stirling High School 1908-1913; Glasgow Academy 1913-1919; M. B. from the University of Glasgow in 1924. Within a year (in 1925), he received the Diploma in Psychological Medicine from the University of London. His own University of Glasgow conferred upon him an M. D. with distinction in 1936. Two years later he was certified by the American Board of Neurology and Psychiatry (1938) and was licensed to practice medicine in the State of New York. At that time he had been married 5 years (since 1933). The Camerons have 4 children.

It is to be noted that he became a member of The American Psychiatric Association in 1931 and a Fellow in 1937. As might have been noted, his initiation into the psychiatric profession began almost immediately after graduation from medical school, and from that moment on this initiation took what for want of any other appellation might be called an Anglo-American turn. He started at the Royal Mental Hospital in Glasgow under D. K. Henderson, a teacher who had been thoroughly exposed to the influence of Adolf Meyer. Already a year later, in 1926, we find him working at the Phipps Clinic, where he held for 2 years the Henderson Research Scholarship in Psychiatry. This was followed by a period at B rghoelzli under the successor of Eugen Bleuler, Hans W. Meier. It was there that he met Dr. A. T. Mathers, who at the time was provincial psychiatrist for the Province of Manitoba. Mathers was a pupil of Southard, and at one time worked on the staff of the Boston Psychopathic Hospital. Cameron was induced to come to Manitoba. It was here that his clinical and scientific interests were happily combined with his endowment as an administrator and teacher.

The years 1929-1936 were thus busy, constructive years of creative work and broad experience. Cameron was in charge of the reception unit of the Provincial Mental Hospital at Brandon, Manitoba; he organized the mental health work in the western part of the province; he established a clinic in the city,

and 9 other centers in the outlying areas that were visited by peregrinatory clinics.

After Worcester (1936-1938), he was called to the professorship of neurology and psychiatry of the Albany Medical College. Cameron was established as a teacher, clinician, and active and prominent member of the psychiatric profession. At the same time, he held the professorship of neurology and psychiatry at the Russell Sage School of Nursing. In 1943 he was called to McGill University, where he has been since and is now professor of psychiatry. He is also psychiatrist-in-chief at the Royal Victoria Hospital and director of the Allan Memorial Institute of Psychiatry, and he serves as a consultant at the Montreal General Hospital and the Verdun Protestant Hospital.

It will have been noted that the first professorial appointment held by Cameron was both in neurology and psychiatry. This combined professorship was not due merely to the fact that psychiatry had not yet been universally differentiated from neurology and given the academic recognition of a separate specialty. As a matter of fact, psychiatry as a specialty was at the time fully recognized by the majority of medical schools in this country. However, Cameron's scientific interests were such that he would not separate organic neurology from psychiatry, physiology from psychology, the human body from the human being. Even a cursory glance through his writing shows the characteristic interests of Cameron, interests that would now be called (although not quite accurately) psychosomatic—or psychobiological—and psychosociological.

He has published close to 80 articles and several books.¹ They deal with the whole range of psychiatric problems and issues: from teaching to epilepsy, from metabolic studies in various psychotic conditions to convulsive therapy and lobotomy, from the psychology of the schizophrenias and depression to problems of psychiatry in industry. Apparently under the influence of the past 2 decades or so of our cultural crises, Cameron's thought has turned to cultural issues, to individualized psychotherapy, and to the

¹ *Objective and Experimental Psychiatry*. New York, Macmillan, 1935. *Life Is For Living*. New York, Macmillan, 1948. *General Psychotherapy*. New York, Grune & Stratton, 1950.

major issues of general psychopathology, such as aggression and anxiety.

Cameron is not an adept of Freud, and at times he appears to be one of the most determined opponents of Freudian psychoanalysis. But he is not a bigot of the opposition. He has confirmed psychoanalysts on his staff, and he sees Freud as a part of the total evolution of psychiatric thought. Cameron's interests seem to be largely cultural when they are not biological; therefore, he was able to say some years ago: "When individual psychotherapists, Dejerine, Janet, Freud, Meyer, had divested themselves of the old idea of abnormal behavior as a disease—which attached itself to the individual like a fungus—and had penetrated to the significance of interpersonal relationships, the development of a body of knowledge concerning the family, the group and the community proceeded rapidly."

Cameron views the "frontiers of social psy-

chiatry" as vast and fascinating, and it is here that he visualizes the opening of the greatest perspectives. The whole process of human development appears to him a slow, long process; therefore, he would not recognize the Romans as *ancients*, for "now that we know that the first traces of man go back for at least half a million years, we have to think of the Romans almost as contemporaries."

In sociology Cameron is a positivist, of course. In psychology he is the proponent of and adherent to the purely scientific tradition that stems from Darwin and Spencer. His biological rationalism and cultural positivism put him at the forefront of what might be called the purely scientific theory of values and rational ethics—a point of view as popular in some circles as it is unpopular in others. But Cameron possesses the courage of his convictions and the greatest respect for the human being as an individual—the latter perhaps despite his consistent scientism.

FUNCTION IN PSYCHIATRY¹

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It is particularly fitting that the American Psychopathological Association should have established a lecture in honor of Dr. Samuel W. Hamilton, whose services in the field of psychopathology have been so diversified and effective for nearly 50 years. Dr. Hamilton was a President not only of The American Psychiatric Association but also of this Association, and for many years as its Secretary was the main force in building it to the large and active organization it is today.

The American Psychopathological Association was founded in 1910, a year before the American Psychoanalytic Association, by psychiatrists discontented with the possibilities for the scientific discussion of psychiatric problems at the meetings of The American Psychiatric Association. When psychoanalysis gathered increasing momentum in America from 1910 to 1925, and psychoanalytic concepts predominated the discussions in the American Psychopathological Association, some of its members felt that the function of this society had been vitiated. However, Dr. Hamilton with a broader grasp, which his wide contact with psychiatric needs throughout the country had brought to him, was convinced of its need. With rare devotion and energy, he sustained and revitalized this organization. Such a society he felt necessary as a forum where not only psychiatrists of all schools might gather but also persons scientifically trained in collateral disciplines.

I feel particularly honored in having been chosen to be the first lecturer in this series, because my admiration and friendship for Dr. Hamilton dates back to 1909. I first met him at Manhattan State Hospital where he was already distinguished for his intellectual honesty, his understanding of the mentally ill, and the sanity of his judgment. Soon thereafter he left New York and our association was interrupted for many years, but on his return our professional association became continuously close, and with it my re-

spect constantly increased for his unfaltering interest in the welfare of all those in the community who were afflicted with mental illness. During the later years of his life these efforts did not wane, even though following a serious illness he felt his strength failing. But it was characteristic of Samuel Hamilton to give his best unstintingly to his life work.

Textbooks on insanity date from the beginning of the nineteenth century, although penetrating treatises on philosophy and psychology long before that time dealt with problems that today would be included in the scope of psychiatry. In one of the earliest books on psychiatry (printed in 1812) the many-sided Benjamin Rush (I, p. 360) stresses the analogy "between bodily and moral diseases" recognizing the latter as psychiatric. With a rare anticipation of the current attitude to mental deviation, he pleads for the substitution of "moral treatment in dealing with vice and crime for the exterminating halter and ax." He writes, "May this Christian system of medical jurisprudence be spread . . . throughout the world! And may the rulers of nations learn from it that the reformation of criminals, as well as the prevention of crimes, should be the objects of all punishments, and that the matter may be effected much better by living than dead examples."

Rush also recognized a strong compulsive drive in the nature of alcoholism and advocated "the establishment of a hospital in every city and town in the United States for the exclusive reception of hard drinkers. They are as much problems of public humanity as mad people. They are not more harmful to society than most of the paranoid patients of a common hospital would be if they were set at liberty" (I, p. 265).

Although all psychiatrists will agree that alcoholism represents a form of emotional disturbance, we have not come to the point where Rush's idea, far in advance of his time, is accepted as correct, proper, may I say, normal by most people. Drunkenness is still regarded as a vice, weakness of volition, crime, or sin, and by relatively few as an ill-

¹ The Samuel W. Hamilton Lecture presented at the meeting of the American Psychopathological Association, New York City, June 1952.

ness falling in the functional domain of psychiatry and functional medicine.

A distinguished contemporary psychiatrist has suggested that the term "skill in living" should replace such terms as mental health and mental hygiene, which it is the psychiatrist's function to develop. A changing viewpoint in regard to alcohol may illustrate the relativism of the norm and "skill in living." Said the "normal" virtuous maiden of the Victorian era, "Lips that touch liquor shall never touch mine. . . ." However, we find the maiden of today no less virtuous but, through a striking change in attitude, she may take a cocktail or two at a public bar and thereby introduce a new "skill in living" in her relationship to a prospective suitor. Both may refer to her drinking as normal and believe that it constitutes a distinct sociological advance in the direction of elevating woman's status in society by allotting her equal rights.

At the beginning of the present century, even in the United States, the social aspects of physical illness were not widely noticed by physicians. They felt that they had completed their function in medicine when the malady from which the patient suffered had been relieved or cured. It was not their concern to consider the economic and sociological conditions that may have produced the illness and were likely to predispose or precipitate a recurrence when the individual returned to the same environment that had been partially responsible for its occurrence.

Social service workers began to make their appearance in scattered hospitals during the first decade of this century. In consonance with a newly developing social consciousness (responsibility) or social conscience, they felt it their first duty to provide financial assistance, food, and housing for the patient who was discharged following a physical illness, so that he might have a better chance of surviving during an interval before returning to his occupation. After a decade, the psychiatric factors that were so often behind the economic, and possibly responsible for the breakdown, and vice versa, gradually came in for attention.

The ultimate in the application of psychiatry to human conduct would be the organization of a world federation for furthering

mental health. This undertaking would integrate actively all the disciplines that have contributed to psychiatry—especially anthropology, with its study of mankind's customs and mores, which include his religious beliefs and ceremonies; pedagogy, with its limitless variations from the type of instruction guided by frequent applications of the birch switch or its equivalents, to the indulgent, almost disciplineless procedures of the extreme in progressive schools; criminology, from decapitation for minor offenses to the careful investigation of all the sociological and psychological factors leading up to the crime. This last has been instituted in some of the states in this country some hundred years after Rush's suggestion. A world attack on mental illness would especially rely on sociology, which attempts to appraise the effect of laws, customs, environment, and climate upon the mental attitudes of various nationalities and races, and above all, to consider the varying concepts of what constitutes mental healthiness and the methods by which the different schools of psychiatry may hope to achieve it.

Perhaps these last factors present at this time the most discouraging aspect of any large-scale mental health endeavor. Certainly the criteria of mental health have varied and continue to vary inordinately—not only at different periods of life but in different eras and places, as the incestuous marriages encouraged by the Ptolemys. As current contrasts we may mention the standards of mental health in Rhode Island and Russia, or in Guiana and Germany. In a book called "Deutsche Seelenheilkunde" (German Psychotherapy) (2), published in 1934, to which 10 well-known German psychiatrists contributed, we find that the preface ends with the words "Heil Hitler" and closes with the sentence, "The physician who wishes to incorporate into himself national socialism must, above all, have scientifically worked through to the last detail and thoroughly grasped Hitler's own words, especially his book, 'Mein Kampf.'" This would imply the acceptance of such ideas as Aryan race supremacy and German domination as a superior race, a philosophy that Goebbels ceaselessly propagandized and may have actually believed. He may have hoped to

establish a new psychological norm acceptable to the German populace, regardless of scientific fallacies. That such convictions can prevail is apparent in certain segments of our Southern states where the advisability of educating Negroes is questioned.

When I first read these words in the book, "German Psychotherapy," they incensed me. However, as I later reflected dispassionately upon this repugnant idea, the proposition of these 10 contributors to the criteria of mental therapy was expedient for that particular time and place. If the aim of the psychiatrist is to put the individual in a position to live and love in accord with the standards of his era, little else could have been done just then for a patient in Germany. Under such a dictatorship survival became practically impossible for the nonconformist.

As long as cultural and moral values are transient and transitory, the patient must be fitted to adapt himself to some current, acceptable scale if he is to exist. Of course this need not be the standard of the psychiatrist, nor should the psychiatrist aim to mould his patient according to his own image. Thus the function of a psychiatrist in Nazi Germany might have been to clarify for the patient the elements entering into his difficulties and even agree to the justification of his momentarily unrealizable potentialities. At the same time, he would have been compelled to acknowledge the inexpediency of using these potentialities at the moment. A thorough nonconforming psychiatrist, or his patient, could not have survived in Nazi Germany—each would have been forced either to disagree and perish, to play false to himself, or to flee from the situation, which the more idealistic psychiatrists as well as their patients and others usually attempted to do in their urge for self-preservation.

In Nazi Germany as under any totalitarian regime, such as Russia today or under the absolutism of the Czars, the range for social integration became restricted in the extreme. An individual psychology, such as psychoanalysis, founded on a theory of ontogenesis and a respect for the integrity of the person, soon evoked an official ban. In a country such as the United States, the latitude of social adaptation is so great that an individual suffering from an advanced schizophrenia

can live in virtual retirement provided he has sufficient private income to maintain himself. The only requirement is that he does not violate this liberal current consensus too flagrantly. Thus a change of environment may at times aid in psychological adjustment because of prevalent appraisal of conduct in the new locality that is more favorable to the patient's pathological conduct.

Often failure to find adjustment in one's environment is symptomatic of a mental disturbance for which a patient seeks treatment—immaturity, overdependence, defiance, disagreeableness. Any pathological disbalance of this type may have been operative in several martyrs to beliefs that have benefited mankind—Joan of Arc and Savonarola come to mind. In contrast, effective social reformers such as Rousseau and Tom Paine were able to place their unfamiliar ideas before a hostile world without suffering too great a penalty for their unrelenting disturbance of current complacency.

A level-headed man like Washington could and did effectively advocate the cause of abolition of slavery by setting his own slaves free in his will, and expressing the hope that a policy of gradual abolition of slavery might be endorsed by the state legislature: "It might prevent much future mischief." . . . In striking contrast, half a century later, the intemperate, perhaps half-crazed John Brown, who had murdered 6 people in Kansas, only added pine logs to smoldering fires by his violence at Harper's Ferry. If all southern slave owners had followed the example of Washington, the entire question of slavery would have been nonexistent in John Brown's day. A new estimate of human rights might have been evolved, which in turn would have required a new skill in living. One hundred years later, the problem of the social freedom of the Negro finds its echo in frequent incidents and opinions (mental attitudes), which may be regarded as healthy or pathological. Some psychiatrists might evaluate them as obsessively neurotic.

Anthropologists have found that acceptance by one's fellows is the only characteristic common to all tribal groups, and the only requirement upon which each group insists is acquiescence to those rules adopted as most

likely to protect it from activities it considers predatory whether these come from without or within. Loosely integrated groups become increasingly important as the social structure becomes more complicated and most of us are members of at least a half dozen major groups. Into 3 such groups a person is born—a sex, age, and color group—which do not change throughout life.

Just as groups are formed for communal security, so too, acceptance by the group provides additional security for the single person. Every individual is first accepted by a group of two—that is, his parents—and no one has stressed more convincingly than Freud the almost ineradicable cultural pattern imprinted upon the child's mind by the primal group. It is likely that this initial acceptance or rejection determines to a degree the individual's adaptation in much of his subsequent social behavior. The threat of exclusion from one's group, especially one's age group, may become a source of great anxiety and fear, designated as neurotic, not too far removed etiologically from Freud's primary "infantile neurosis."

Thus a patient, who could have been designated either as neurotic or schizophrenic, had great difficulty in adaptation to any group. The difficulty was attributable primarily to the threat of his parents from an early age that he would be thrown out of the house if he were not good, and which determined much of his subsequent conduct. His mother would reprimand or, as he put it, "bitch" him, and then if he did not conform to her demands she would threaten to report him to his father, that is, "snitch" on him. . . . These 2 threats he could stand, but when both parents threatened to put him out on the street, that is, "ditch" him (abandon him), his terror knew no bounds. His habitual pattern of conduct could be summarized in a series of defences against being "ditched." . . .

Of course, for a happy survival within the family, the child must conform more or less to the multiple ideals of his parents, who have diverse standards of propriety. As the original group of three, parents and first child, increases through the addition of other children to the family, the child's age group expands through contact with other children of the same age and the need for conformity becomes more imperative.

Perhaps one may even trace the origin of class distinction to the relationship of children within the family to one another, where

privilege is based on age, the groups being divided into older and younger. It continues in the process of growing up, through college days and beyond. It is especially noticeable when 5 years or more separate children in the same family.

Groups that form more or less spontaneously and voluntarily expand or contract in size according to the degree that conformity to them requires full renunciation of the members' individual rights. Capacity for such yielding to group demands is perhaps the most important element in merging with the group, so often undertaken for protective advantage. The willingness to give away something of one's self is probably fundamentally dependent on the greater gain for the self, which in every instance is relative, to be achieved through this apparent self-denial. If the desire for selfish gain becomes too apparent when the individual joins the group, his allegiance is quickly discerned as doubtful by the more loyal members. Such persons cannot renounce self-interest without feeling they expose themselves to great danger. Thus the patient previously mentioned, retaining his early fear of being "ditched," found it almost impossible to participate in any joint enterprises from primary school through college and business days.

The function of the psychiatrist then resolves itself into efforts to place the patient in a position where he can live and work in a manner permitted by the group within the limits of a variable norm. In a totalitarian society this may be easier for a vacillating patient because only one choice remains open. However, with an aggressive dissenter the conflict is intensified because a partial acquiescence to the regime is excluded.

Try as he may, it is impossible for the psychiatrist to evade opinion as to what is the norm with its moralistic imputations and what is neurotic or psychopathic in the actions of his patients. His acceptance of a patient implies that in some respect this individual is a deviant from a contemporaneous norm to the degree that he requires treatment, whether it be in so severe a form of suspicion as paranoia or vague complaints about the actions of some individuals as being unfriendly. At times the concepts of normalcy in psychiatric language and in ethics—the

science of the good and the nature of the right—approximate each other so closely that the psychiatrist is forced to consider ethical standards in appraising situations involving guilt, shame, punishment, and threat, which in their neurotic form precipitate many mental illnesses.

One patient remarked that the great weakness of Christian ethics is the doctrine of meekness, which people cannot live up to and leads to the adoption of conduct in which hypocrisy and deception must be continuously practiced. The hypocrite and the cheat, in turn, must preserve themselves through a defensive projection of their weakness, which would manifest itself in suspicion of their fellows, or an overcompensatory servility and unctuousness. The patient who complained about Christian ethics, consciously overeffacing and oversolicitous, in the next breath protested that "we should have the right to defend ourselves"—in other words, freely to exercise the capacity for aggression.

I would cite an example of a situation in which the psychiatrist could not help but assume a position because it threw the patient into a depression. She was a housewife referred for depressions and a recurrent compulsion. After she had been under treatment for over a year, her husband, a vice-president in a bank, told her that he had been invited by the director of another large bank to lunch with him and had been offered the executive vice-presidency of a branch that this second bank was about to open in a suburb. He said nothing to her about keeping it a secret, but merely that he had not decided whether to accept the proposal. On the following afternoon, while having tea with her mother-in-law, the patient mentioned that her husband was being considered for the head of the suburban bank and that she was happy at the proposed promotion. Her mother-in-law also appeared very pleased. However, that evening when she told her husband how pleased his mother had been, he scolded her severely and said that she had divulged a secret that might embarrass him greatly. When she asked him why, he replied, "If it gets abroad that I have been offered this position and refused it, it will make it very embarrassing for the man to whom it is offered as a second choice." . . .

I am not at all sure how the majority of my listeners would regard the conduct of either the wife or the husband, and which would most nearly approximate a normal reaction. The psychiatrist must consider whether or not the husband's attitude reflected an unusual degree of secrecy,

one of his characteristics that annoyed his wife intensely, whether he projected his dissatisfaction because of his failure to be advanced in his original position upon his wife in finding fault with her, or whether the wife's reactive depressive and antagonistic mood is to be regarded as a pathological reaction indicating that she had made little progress as a result of treatment.

Generally speaking, the psychiatrist can function more advantageously when his background and that of the patient are not too grossly divergent because this facilitates mutual understanding. By this I do not wish to imply that, for example, Catholic psychiatrists from a cultured background should restrict themselves solely to Catholics of similar cultural heritage. But the chances are that the empathy would be greater than between Protestant and Catholic, whether patient or doctor. The same may be said of Negro and white, Jew and Christian, totalitarian and democratic, and English and Spanish. However, it is interesting that, where choice is possible, such a selection is made by both doctor and patient—not only in psychiatric cases but in general medical practice as well.

Every psychiatrist in the course of his career has been deserted by a patient because the latter felt that his individual biases, actual or fancied, could not be reconciled and interfered with the proper assessment of deviations for which the patient came for treatment. So too, it is preferable that the judgment of the degree of illness be made and therapy conducted in the country in which the patient resides and in his native tongue. With the airplane annihilating distance, a universal, cosmopolitan background seems in the not far distant future destined to replace the nationalistic. But until this occurs the psychiatrist can best function in a restricted sphere where he and his patient feel most at home.

This concept of the immediate scope of psychiatry would center its efforts in localism and homogeneity. Admirable as the idea of synchronization of effort may be, it leaves little hope in our day for a movement aiming at a universal approach to mental health. The obligation of the individual to authority even in a restricted area is too varied and in many

cases so inviolable that the best the psychiatrist can do is to put his patient in better harmony with himself so that he may thereby find a means of living with the leadership of his time.

This idea of measuring the psychiatrist's efforts, not by the knowledge of or adherence to a theory, but by practical outcome and feasibility within the range of the current ideal, coincides with the pragmatism of William James. But James' psychology, which holds that ideas to be considered true must be verifiable by an impartial observer, originated in a land where the regard for authority is relatively slight and where impartiality and respect for the single person's independence is widespread. Long before James developed the theory of pragmatism, he expressed his reverence for the force of the individual's ultimate influence in a memorable passage:

As for me, my bed is made; I am against bigness and greatness in all their forms, and with the invisible molecular moral forces that work from individual to individual, stealing in through the cranies of the world like so many soft rootlets, and yet rending the hardest monuments of man's pride, if you give them time. The bigger the unit you deal with, the hollower, the more brutal, the more mendacious is the life displayed. So I am against all big . . . successes and big results; and in favor of the eternal forces of truth which always work in the individual and immediately unsuccessful way, underdogs always, till history comes, after they are long dead, and puts them on the top.

Mental health is dependent upon the extent of the awareness that a person has attained in his relationship with his fellow beings and the feeling of security with which he is able to meet such awareness. This secu-

rity would rest upon the degree to which he can attain self-realization within the limitations of the group standard. Of course, primary security depends upon the fulfillment of the need for food and love, of which diverse and wide ramifications are observable under varying cultural conditions and in different individuals under the elastic social standards of America.

The psychiatrist's aim resolves itself into enabling the individual to adapt himself to some form of the cultural pattern under which he lives. The individual must be helped to achieve an acceptable solution of the ever-recurring struggle between his conscience, derived from the negations and affirmations of his parents, plus the ever-changing social impacts of his associates, and his own self-interest and greed.

Having exposed the motives for the abnormality, he must point out to the patient how the defenses produced by conflict have operated against the patient's stability and efficiency, either in the form of overaggression or disadvantageous submissiveness. It behooves the psychiatrist to be liberal and independent of rigid conventions in the investigation of the factors responsible for the patient's deviant conduct and to incline the weight of his authority gently in the direction of those forces directed toward the advance of human dignity.

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INTELLECTUAL AND AFFECTIVE FUNCTIONS IN CHRONIC BRUCELLOSIS¹

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Recently Apter *et al.* (3, 4) have described a number of patients with chronic brucellosis studied from the combined viewpoints of medicine, neuropsychiatry, and experimental psychology. Their findings substantiate earlier descriptions and more precisely specify the symptomatology in this disease. A summary statement by these authors indicates that patients with chronic brucellosis complain of "... headache, easy fatigability, inability to return to work, loss of former skills, insomnia without somnolence, change in sexual habits and decreased ability to adapt in social situations" (3). In addition, "Their psychiatric state is characterized by defects in the intellectual sphere, impoverished emotional expression, reduction in motility, inability to plan for the future and failure to develop rapport." These investigators conclude that the over-all picture in brucellosis may in many instances be one of organic brain disease. This conclusion would seem tenable in light of their historical survey of long-standing findings of neuropathological involvement in brucellosis, and seems secured by the results obtained through careful evaluation of their patients.

The neuropsychological aspect of the study by Apter *et al.* was performed by Halstead, and is perfectly compatible with the conclusions reached by medical and neuropsychiatric evaluation. Halstead found in his quantitative measurements of biological intelligence in these patients rather marked impairment, in some instances "... similar to that found in patients with neurosurgical removal of the prefrontal lobes." This result was obtained sometimes in the absence of neurological signs. In another instance that these authors (3) report, however, brucellosis does not seem to have brought about any organic brain damage. In this patient psychosomatic and hysterical complaints developed during the course of chronic brucellosis, although there was no evidence of organically impaired cerebral functions. The authors em-

phasize the importance of having available a method of differentiating patients with organic cerebral involvement as a result of brucellosis from those who develop psychosomatic complaints similar to those in any other chronic illness. They cite Halstead's measures of biological intelligence as such a method.

In a recent study (11), the present writer has found marked relationships between the results of the Rorschach inkblot test and the abstraction factor of biological intelligence as well as the Halstead Impairment Index. Although the Halstead battery undoubtedly provides a largely valid basis for the evaluation of psychological functions dependant upon an organically healthy brain (8), these tests are generally unavailable. The Rorschach inkblot test, on the other hand, is being used more and more extensively. The relationships found between the Rorschach test and Halstead's measures suggest the possibility that organic intellectual impairment in brucellosis might also be reflected by the Rorschach test. For this reason, in the present study an attempt has been made to evaluate the psychological functions of a group of patients with a diagnosis of brucellosis by means of the Rorschach test.

POPULATION

Twenty-eight subjects with brucellosis, including those reported by Apter *et al.* (3, 4), were used in the study. Two other groups were also used for purposes of comparison. These were 28 neurotic patients, sufficiently disturbed to seek psychiatric assistance but without evidence of organic central nervous system damage, and 28 persons with verified organic brain damage or dysfunction.

The diagnostic classification of the patients in the neurotic group were as follows: depression, 18; anxiety neurosis, 3; obsessive-compulsive neurosis, 3; alcoholism without deterioration, 1; and simple schizophrenia, 3. The composition of the group was partly determined by the necessity for selecting neurotic patients who matched the brucel-

¹ From the Department of Surgery, Indiana University Medical Center.

losis patients on the basis of sex, age, education, and IQ. The large proportion of depressed patients, however, was deliberate. It was felt that the depressed patients would be similar in certain respects (*e.g.*, slowness of reaction) to the brucellosis and brain-damaged patients. If superficial similarities between the groups were thus roughly equated, it seemed that any differences found would be more apt to represent differences reliably indicating the effect of any organic deficit in the brucellosis and brain-damaged groups. An effort was made to introduce heterogeneity in the remainder of the group, and this was the reason particularly for inclusion of 3 nondeteriorated schizophrenics and the alcoholic subject. None of the subjects in the neurotic group gave any neurological evidence of organic central nervous system involvement, nor did their histories contain indications of such. There was definite evidence of organic brain damage and/or dysfunction for each of the subjects in the brain-damaged group. After satisfaction of this requirement, the subjects were selected pretty much at random in accordance with those matching the brucellosis subjects on the basis of the equated variables. The group included 6 patients with surgical removal of brain tumors, 6 with epilepsy, 5 who had cerebral vascular accidents, 8 with degenerative vascular changes, and one each with a penetrating head injury, a closed head injury, and general paresis. The diagnosis of brucellosis was bacteriologically proved by recovery of the *Brucella* organism in most of the patients so diagnosed, although in some instances (largely because of the duration of the illness before examination) the diagnosis was based on strongly suggestive collateral evidence.

The subjects in the 3 groups were individually equated with regard to sex, and as closely as possible with regard to chronological age, number of years of formal academic education, and IQ. Each group consisted of 16 men and 12 women. The means and standard deviations for each group on these variables are presented in Table 1. It will be noted that the mean values are approximately equivalent in the 3 groups. These means were compared by Student's *t* technique for correlated groups and none of the differences reached significance at the

.05 level of confidence. It seems safe to conclude that the 3 groups are sufficiently well equated to rule out any systematic intergroup differences with regard to the equated variables.

PROCEDURE

Generally stated, the procedure was to compare the 3 groups of subjects with regard to measures provided by the Rorschach test relevant to the intellectual and affective differences that might exist in these diagnostic categories. The variables on which the groups were equated are ones that might possibly be relevant to the performance on the Rorschach test, but that we did not wish to measure in this particular investigation. The central problem of this study was to de-

TABLE 1
DISTRIBUTION CONSTANTS FOR 3 EQUATED GROUPS

Neurosis	Age	Education	IQ
Mean	40.82	11.43	89.79
S.D.	11.57	2.78	20.25
Brucellosis			
Mean	40.02	11.00	89.56
S.D.	10.30	3.35	22.75
O.B.D.			
Mean	38.14	11.03	90.02
S.D.	10.62	3.36	19.94

termine whether or not the Rorschach test provides any basis for measurement of differences in psychological functions in patients with brucellosis as compared with those with neurosis and organic brain damage.

The selection of neurotic and brain-damaged groups for comparison was based upon previous descriptions of psychological functions in patients with brucellosis. It was felt that the use of neurotic and brain-damaged patients might set reasonable boundaries within which the performance of the brucellosis patients might be more adequately assessed. The neurotic patients should reflect in their test results no organic impairment of intelligence but rather a preponderance of environmentally produced or personality problems. The organic brain-damaged subjects should show impairment of intellectual functions (9-13) as well as rather characteristic affective personality difficulties (1, 2,

5, 7). The intergroup comparisons, then, should give some basis for describing the extent to which patients with brucellosis resemble the neurotic and/or the brain-damaged patients.

The Rorschach was administered to each of the subjects individually and the scoring completed before any of the groups were composed for study or the subjects matched on the controlled (equated) variables. The test protocols were scored following the method suggested by Beck(6). The means and standard deviations for the quantitatively scored Rorschach variables were calculated. Intergroup statistical comparisons of the means were made by use of Student's *t* technique using the method for correlated groups. As another approach to the quantitative differentiation of the 3 groups, the frequencies with which Rorschach scores of members of one group exceeded the scores of the paired individuals in the other groups were enumerated, and the frequency differences tested for significance by use of the chi-square test with Yate's correction for continuity. Also, chi-square comparisons of the frequency of occurrence of various Rorschach "signs" of organically impaired cerebral functions in the 3 groups were made. Finally, the Rorschach records were reviewed in an effort to discover consistencies in interpretation of personality factors that would differentiate or characterize the 3 groups.

RESULTS AND DISCUSSION

Table 2 presents the means and standard deviations obtained by the 3 groups on various Rorschach variables. It will be noted that the mean values rather consistently fall in the following order from highest to lowest: neurosis, brucellosis, and organic brain damage(hereafter referred to as OBD). This trend, however, becomes much more apparent with a graphic representation of the mean values, the scores for each variable being put on an equivalent scale. Fig. 1 portrays the information in Table 2 in this form.

For ease in comparison, Fig. 1 presents a subfigure for each combination of pairs among the 3 groups and a summary subfigure in the lower right corner of the figure. The equivalent scales for the Rorschach vari-

TABLE 2
DISTRIBUTION CONSTANTS FOR 3 DIAGNOSTIC GROUPS ON RORSCHACH VARIABLES

	R	W	D	Dd	M	Sum	Z	F+	F-	Total	CF	FC	Total	C	YF	FY	Total	Y	FV	S	P	T/R	$\frac{Z}{T/R}$	$\frac{Z}{R}$
Neurosis																								
Mean	36.96	7.50	22.43	7.00	3.43	5.54	34.80	13.68	5.89	21.11	3.54	2.43	6.39	1.29	1.29	3.57	4.96	1.04	3.20	7.32	52.89	.82	1.22	
S.D.	26.01	4.78	14.98	13.88	4.38	3.85	23.63	9.24	11.38	19.06	2.82	2.08	4.06	1.58	1.58	2.04	3.91	.87	2.88	3.16	26.36	.62	.61	
Brucellosis																								
Mean	30.86	6.75	19.89	4.21	3.71	3.41	37.61	13.54	4.14	18.75	1.89	1.79	3.96	.75	.75	2.36	3.11	1.18	2.39	6.57	58.11	.78	1.35	
S.D.	23.11	4.11	15.68	6.54	4.10	2.35	32.39	10.30	5.40	15.84	1.59	1.54	2.58	1.30	1.30	2.42	3.43	.85	4.88	3.26	20.85	.74	.72	
O.B.D.																								
Mean	20.64	8.25	11.61	.79	2.57	3.13	32.25	7.50	3.75	11.93	2.07	1.21	3.54	.21	.21	1.79	2.00	.57	1.35	5.64	63.89	.74	1.58	
S.D.	10.57	5.86	6.76	1.23	2.29	2.97	20.85	4.20	3.21	5.26	2.74	1.23	3.22	.56	.56	2.23	2.43	.78	1.47	3.11	31.78	.90	.59	

ables were constructed by combining the 3 groups and converting the raw scores for each variable into T-scores. The ordinates for the graphs in Fig. 1 are, therefore, T-score scales. The raw score means for each group were plotted on the graphs in accordance with their equivalent T-scores. The advantage of an equivalent or standard score scale is that it permits an evaluation of the general trend in comparing 2 or more groups.

It will be noted from Fig. 1 that the mean

scores, the brain-damaged subjects the lowest, and the brucellosis subjects generally fall in between.

Although the trend indicated by the above graphs indicates an over-all difference between the 3 groups, it is of interest to compare the means for the variables individually. The differences between means for each group were tested for statistical significance by Student's *t* technique, and the *t* ratios are presented in Table 3.

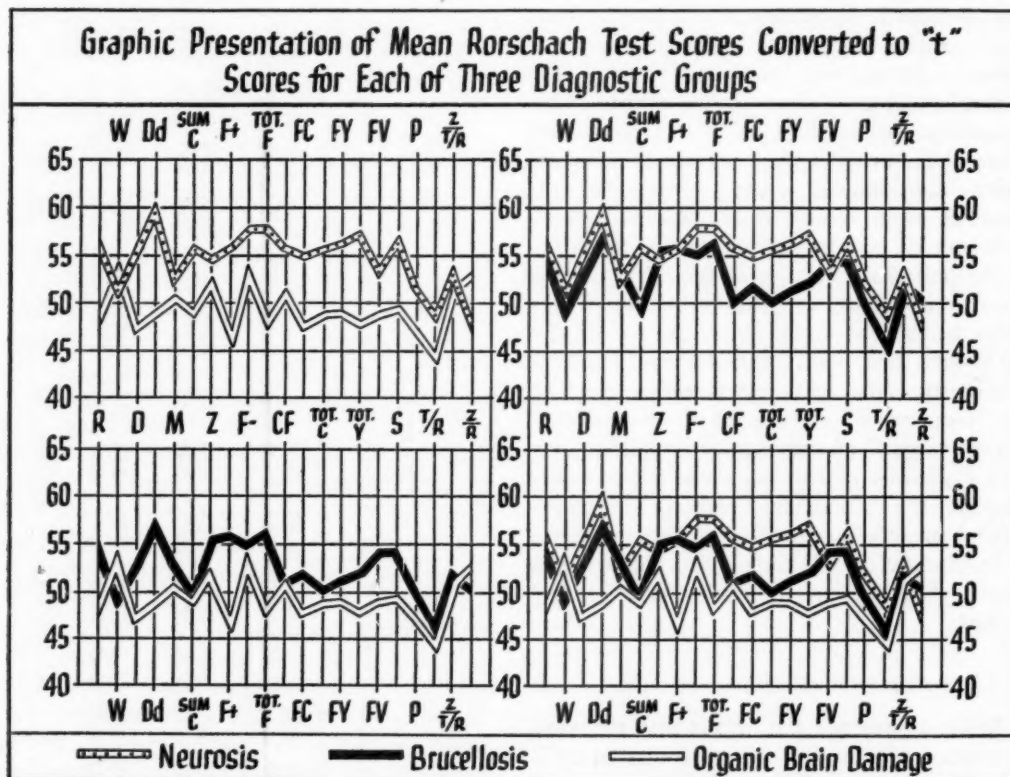


FIG. 1.

scores for the neurosis group rather regularly exceed those for the OBD group (upper left graph). The means for the subjects with brucellosis also exceed those for the brain-damaged subjects (lower left), but the differences are not as great. This becomes more apparent in the neurosis vs. brucellosis comparison (upper right), inasmuch as the neurotic subjects quite consistently exceed those with brucellosis. From these comparisons the general trend is apparent, viz., that the neurotic subjects show the highest mean

For 27 degrees of freedom a *t* ratio of 2.77 is needed to reach the .01 confidence level, 2.47 for the .02 level, and 2.05 for the .05 level. In comparing the neurotic and OBD groups, 8 *t* ratios are significant beyond the 0.1 level, 2 beyond the .02 level, and an additional 4 beyond the .05 level. The variables are R (number of responses), D (number of major detail responses), Dd (number of minor detail responses), Sum C (sum of quantitative values assigned for responses using color), F+ (number of "good form"

TABLE 3
COMPARISON OF MEAN DIFFERENCES BETWEEN RORSCHACH VARIABLES FOR 3 DIAGNOSTIC GROUPS BY MEANS OF *t* RATIOS

Groups	R	W	D	Dd	M	Sum C	Z	F+	F-	Total F	CF	FC	Total C	YF	FY	Total Y	S	P	T/R	Z/R
Neurosis vs. brucellosis.....	.82	.68	.53	.87	.27	2.32	.44	.05	.68	.44	2.70	1.33	2.59	1.34	.17	1.78	.90	.86	.76	.69
Neurosis vs. O.B.D.....	3.08	.46	3.46	2.28	.90	3.06	.40	3.27	.93	2.10	2.23	2.64	3.51	3.60	2.59	3.18	3.10	2.00	1.29	.37
Brucellosis vs. O.B.D.....	2.06	1.05	2.61	2.76	1.37	.35	.70	2.75	.32	2.09	.30	1.37	.47	1.94	1.14	1.52	1.07	1.41	.83	1.13

responses), Total F (total number of responses determined only by form), CF (number of responses in which color predominates form), FC (number of responses in which form predominates color), Total C (total number of responses using color), YF (number of responses in which surface-shading predominates form), FY (number of responses in which form predominates surface-shading), Total Y (total number of responses using surface-shading), S (number of responses using white spaces), and Z/R (amount of organizing per response).

Each of these significant mean differences was in the expected direction, *i.e.*, the neurosis group mean being higher, with the exception of the Z/R ratio. Rather little is known about this ratio. Previous investigations have shown Z, a quantitative estimate of the amount of organizing of the inkblots and establishing relationships between associations, is somewhat lower among brain-injured than control patients. But at the same time, the number of responses, R, also tends to be somewhat lower, which would leave the Z/R ratio relatively unaffected. In the present study the total amount of organizing does not differentiate the neurosis and OBD groups, but the mean number of responses for the OBD group is significantly lower. This would raise the magnitude of the Z/R ratio for the OBD group. However, since Z is usually found to be lowered with brain damage (2, 12, 13) it would appear that the result obtained with Z/R in the present study is probably a reflection of a sampling peculiarity that would not often reoccur if the study were repeated.

With one exception, the means for the brucellosis group fall between the neurosis and OBD means on the 14 variables that differentiate the latter 2 groups. The exception is CF, a measure on which the brucellosis mean is the lowest of the 3. The mean score for the brucellosis group is not significantly different from either the neurosis or OBD means for the following variables: FC, YF, FY, Total Y, S, and Z/R. On certain variables, however, the brucellosis means join with those of the OBD group in differing significantly from the neurosis means. These variables are Sum C, CF, and Total C. It is interesting to note that these 3 measures on which the brucellosis patients

resemble the brain-damaged in contrast to the neurotic subjects each involve responses to color. It would appear from this result, in terms of Rorschach test interpretation, that patients with brucellosis and organic brain damage share a common reduction of emotional spontaneity and capacity for emotional responsiveness. On the other hand, the brucellosis subjects deviate on some variables in the direction of the neurosis group means and join them in differing significantly from the OBD group. These are R, D, Dd, F+, and Total F. These variables (particularly R and F+) are traditionally aligned primarily with intellectual rather than affective indicators in the Rorschach test. Generally it would appear then, from these results, that patients with brucellosis resemble neurotic subjects with regard to the adequacy of certain intellectual functions, are similar to brain-damaged patients with regard to the extent of their emotional dulling, and tend to fall between neurotic and brain-injured subjects, differing significantly from neither, with respect to other affective and intellectual functions. It would probably be inappropriate to conclude that no differences between these groups exist with respect to variables for which the means did not differ significantly, particularly in consideration of the marked orderliness of the graphs in Fig. 1. If larger groups were studied perhaps additional differences would sufficiently satisfy statistical criteria to merit emphasis.

As another approach to possible differentiation of the quantitative results for the 3 groups, the number of individuals in one group whose scores exceeded those for the matched individuals in another group was determined for each variable. For example, the number of neurotic subjects who had a greater number of responses (R) than did the matched subjects from the brucellosis group was counted, and vice versa. Chi-square was then used with Yate's correction for continuity to determine the significance of group differences. The comparisons in which the chi-square values reached the .01, .02, and .05 levels of confidence are indicated in Table 4.

There were no reversals that reached statistical significance in the comparisons summarized by Table 4. This means that for no variable did the brucellosis group signifi-

TABLE 4
RESULTS OF CHI-SQUARE TESTS OF FREQUENCY WITH WHICH SCORES OF MEMBERS OF ONE GROUP SIGNIFICANTLY EXCEEDED SCORES OF PAIRED INDIVIDUALS IN ANOTHER GROUP

Confidence level	R	D	Dd	Sum C	F+	Total F	CF	FC	Total C	YF	FY	Total Y	FV	S	T/R	Z T/R	Total II
Neurosis > O.B.D.	x	x	x	x	x	..	x	..	x	x	x	x	..	x	..	..	3
	x	..	..	..	..	x	..	..	..	1

Brucellosis > O.B.D.	x	..	x	..	..	..	..	2
	..	x	..	..	x	..	..	..	..	..	..	..	..	..	..	..	2
	x	..	..	..	..	..	..	..	..	..	..	..	..	..	1

Neurosis > brucellosis	x	..	..	x	..	..	..	..	..	..	2
	x	..	..	..	..	..	..	..	x	..	x	..	..	3
	x	..	x	..	..	..	..	..	2
	3
	x	..	..	..	..	..	2

cantly exceed the neurosis group, the OBD group the brucellosis group, or the OBD group the neurosis group. The neurosis group significantly exceeded the OBD group on a large number of variables, including those with primary meaning for intellectual as well as affective personality functions. The neurosis group also exceeded the brucellosis group on a considerable number of variables, but these variables were generally more closely related to affect. The brucellosis group exceeded the brain-damaged group on several variables, some primarily affective and others intellectual. The results of this procedure verify fairly closely those obtained with the *t* tests for significant mean differences: (a) the widest and most general differences are found in comparing the neurosis and OBD groups, and (b) the brucellosis subjects tend to fall between the other 2 groups, but are more similar to the neurotics with respect to intellectual functions and to the OBD group with respect to diminished capacity for affective reactivity.

The Rorschach records in the 3 groups were also studied with reference to the frequency of occurrence of various "signs" of impaired psychological functions due to organic brain damage. Fourteen signs were used: 5 of the 10 that were proposed by Piotrowski(10) and 9 that were proposed by Aita, Reitan, and Ruth. Only those 5 of the Piotrowski signs that had been previously found to differentiate between brain-injured and control subjects(2) were included. The relevance of these signs to intellectual functions dependant upon the organic condition of the cerebrum is indicated by their significant correlations with Halstead's(8) measures of biological intelligence(11).

Fig. 2 presents a graphic comparison of the relative frequency with which the signs occurred in each group. Each sign is indicated on the horizontal axis, and along the vertical axis "most," "middle," and "least" indicate the comparative frequency of the signs in the 3 groups. When the same number of persons in 2 groups evidenced a particular sign, the 2 groups are indicated at the same point on the graph, the point being an average of the 2 positions not occupied by the third group.

It is apparent from Fig. 2 that the marked trend noted in Fig. 1 is again present. The

OBD group tends to have the greatest number of signs of organic brain damage, the neurotic group the fewest, and the brucellosis group tends to fall in between. This result strongly substantiates the results presented in Fig. 1, since the same trend is present even though the graphs are based on entirely independent measures from the Rorschach test.

Table 5 presents the chi-square values, computed with Yate's correction for continuity, which present a basis for determining the statistical significance of the frequency differences among the 3 groups for individual signs. Not many of the chi-square values are significant. Most of the significant differences are found in comparing the neurosis and OBD groups. In this comparison 2 signs (impotence and perplexity) differenti-

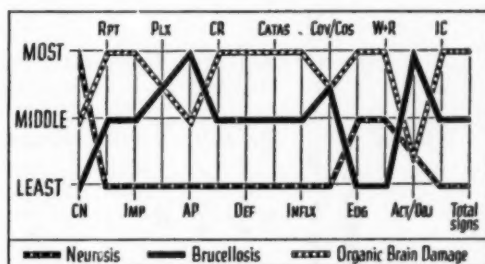


FIG. 2.

ate the groups beyond the .01 confidence level and 2 more (catastrophic reaction and inflexibility) beyond the .02 level. Three of the signs significantly differentiate the neurosis and brucellosis groups: perplexity, beyond the .01 level; automatic phrases, beyond the .02 level; and impotence, beyond the .05 level. Interestingly, the chi-square tests suggest that the differences in the frequencies of these signs of brain damage between the brucellosis and OBD groups are not sufficiently large to attribute to anything but chance variation. It would seem from these results, then, that the patients with brucellosis more closely resemble the brain-damaged than the neurotics in this particular comparison. The brucellosis group deviates from the neurotics in the direction of the OBD group particularly with respect to impotence, or doubting of the adequacy of responses with inability to either withdraw or improve them, and perplexity, or the subject's distrust of his own ability together with a request for reassur-

TABLE 5
CHI-SQUARE VALUES COMPARING THE FREQUENCY OF OCCURRENCE OF RORSCHACH "SIGNS" OF BRAIN DAMAGE IN 3 DIAGNOSTIC GROUPS

Groups	Cn	Rpt	Imp	Plx	AP	CR	Def	Catas	Infix	CovCds	Edg	W&R	ActObj	IC	Total signs
Neurosis vs. brucellosis.....	.52	.52	4.29	9.41	6.41	1.16	0	2.42	2.62	2.62	0	.27	.78	0	21.33
Neurosis vs. O.B.D.....	0	3.51	12.65	9.41	3.04	2.57	1.16	5.87	5.97	2.62	0	.53	0	2.42	42.32
Brucellosis vs. O.B.D.....	0	.65	1.79	0	.32	.07	.66	.45	.37	0	.25	2.62	.78	.88	3.87

ance from the examiner. Again it should be mentioned in consideration of the general trend shown in Fig. 2 that many more of these differences might have reached significance had the groups been larger and had Yate's correction not been used. Therefore, it seems wise to avoid placing any heavy emphasis on chi-square values comparing the intergroup frequencies for individual signs.

The chi-square values comparing the total number of signs occurring in each group reflect a highly significant difference ($p < .001$) between the neurosis and OBD groups and also between the neurosis and brucellosis groups. The difference between the OBD and brucellosis groups, however, just exceeds the .05 level. Again, the patients with brucellosis appear to resemble more closely those with organic brain damage than neurosis.

A review of the Rorschach records was made in an effort to determine any outstanding features in interpretation with respect to which the 3 groups appeared to be similar or different. As would be expected, the records of the neurosis group showed marked neurotic trends and, in a few instances, psychotic symptoms. The OBD group consistently gave evidence of organic brain damage, and as has been found consistent with brain damage (1, 2) also showed a good deal of anxiety and depression. These patients' anxiety seemed to be centered around concern for the adequacy of their eventual adjustment as well as their physical condition. The brucellosis group showed much more heterogeneity from the viewpoint of personality structure. Evidence of organic brain damage, anxiety, and depression was present in many of the test records. A few gave records resembling those of hysterical patients, and a few were essentially normal. As a result of this diversity, each patient with brucellosis was subjectively rated on 4 scales: organic brain damage, depression, anxiety, and hysteria. Three points were used to note the intensity of the indication for each scale: mild, moderate, and strong. This scale suffers distinct limitations for 2 reasons: (a) the absence of information regarding its reliability, and (b) possible inconsistency between the writer and others with regard to the meaning of "mild," "moderate," and "strong." Nevertheless, it

may be of some interest to present the results obtained with the ratings (Table 6).

A good deal of overlap is present, *i.e.*, many of the subjects were positively rated on more than one scale. From the test records, neurotic symptoms appeared to be present to an extent deviating from normal in all but 4 of the patients with brucellosis. Eight subjects give only neurotic signs without any indications of organic cerebral involvement, but 16 showed signs of brain damage together with neurotic symptoms. Only 4 patients gave Rorschach records that were essentially normal. Even though such a large proportion gave evidence of neurotic problems, these results seem to be consistent with those presented earlier. Anxiety, depression, and the other neurotic symptoms were probably present to a considerable ex-

brucellosis. The subjects were individually matched in the 3 groups on the basis of sex, age, formal education, and IQ. Intergroup statistical comparisons were made of the mean performances on each of the Rorschach variables. Secondly, the frequency with which scores in one group exceeded the matched scores in the other groups was tabulated and the frequency differences tested for statistical significance. The relative frequencies of Rorschach "signs" of organic cerebral damage in the 3 groups were also compared statistically. The results obtained indicate quite consistently that the scores of subjects with brucellosis fall between those of the other 2 groups. Generally, the brucellosis group is more similar to the neurosis group with respect to Rorschach variables having primarily intellectual significance,

TABLE 6
DIAGNOSTIC INDICATIONS PRESENT IN RORSCHACH RECORDS OF 28 PATIENTS WITH CHRONIC BRUCELLOSIS

	OBD	Depression	Anxiety	Hysteria	Essentially normal
No indication	12	12	4	23	4
Mild indication	5	6	7	3	
Moderate indication	9	10	15	2	
Strong indication	2	0	2	0	
	28	28	28	28	

tent in all 3 groups, but the additional presence of cerebral damage or dysfunction in the brucellosis and OBD groups would tend to make their quantitative results somewhat more similar than the brucellosis and neurosis groups. These results emphasize the frequency of neurotic symptomatology among patients with brucellosis, but at the same time confirm the findings of impaired psychological functions as a result of organic cerebral damage in some of these patients.

The results obtained in this study, based upon analysis of Rorschach protocols, are essentially similar to those obtained by Apter *et al.* (3, 4) through the combined use of internal medical, neuropsychiatric, and psychological methods.

SUMMARY

The Rorschach test was administered to 3 diagnostic groups composed of patients with neurosis, organic brain damage, and

and more similar to the brain-damaged group with respect to reduction of emotional spontaneity and capacity for emotional responsiveness. The various Rorschach "signs" of brain damage occur much more frequently in brucellosis than neurosis ($p < .001$). While these signs occur more frequently among brain-damaged patients than those with brucellosis, the statistical significance is not as great ($p < .05$). An interpretative review of the protocols in the 3 groups indicates a considerable amount of neurotic symptomatology in each group, but confirms the earlier result of typical indications of organic brain involvement occurring among the patients with brucellosis as well as those with verified brain damage.

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GROUP PSYCHOTHERAPY IN ASSOCIATION WITH ALCOHOLICS ANONYMOUS¹

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The limitations of medicine have possibly never been so easily recognized as in the treatment of the alcoholic patient. This paper is a description of a therapeutic regime that has been set up in a Veterans Administration Hospital that incorporates a recognized group of The Alcoholics Anonymous Foundation. This particular treatment program is carried out on the acute-intensive treatment psychiatric service, and is under the over-all supervision of the chief of that service.

The importance of the emotional etiology that is presented symptomatically as alcoholism has not been so fully accepted as have other symptoms of emotional instability. Time as a factor in treating any patient with an emotional disorder is often forcibly abbreviated by both the therapeutic team cognizant of the limitations of bed space and by the patient who usually prefers treatment of his physical disability to therapy for his emotional disturbance.

In reviewing the literature we note that many types of programs (1-3, 5-7, 10, 12, 15, 19-21) have been suggested for the treatment of the alcoholic. Psychotherapy for the individual has as many devotees (8, 16-18) as has the group technique (4, 9, 13, 14). Meyer (11) states: "Much of this work of adjustment is carried on upon a strongly individualizing basis; even then, in the end, there will always be persons who do best when treated in groups, with the help of a sense of belonging and being accepted." "Group interaction," Mueller writes (13), "is the basic medium for the release of emotional difficulties."

Alcoholics Anonymous satisfies the re-

quirements for such a working medium and would seem to provide the method of choice for the treatment of the alcoholic both in and out of the hospital. Yet in reviewing the literature such statements as these are found: "Efforts to establish a bona fide Alcoholics Anonymous group in the barracks setting, despite the desire of some of the barracks members, have met with little success, owing to the apathy of administrative channels from which the approval would have to come for the establishment of such a group" (12); "We hoped to have our men continue with A. A. but this failed" (4).

In summarizing this literature it is found that the most successful regimes postulate intensive control in the posthospital period. In the Veterans Administration the majority of patient care is available only to service-connected cases, which unfortunately precludes most alcoholics.

It was with the above points in mind that a procedure had to be evolved that would give the patient some method of posthospital care.

Both local and out-of-state A. A. members are free to visit the hospital group. One such out-of-stater, a traveling salesman, and to that date 18 months dry, related to the group that during his last hospitalization in a distant city he had asked permission of the hospital personnel to call the local A. A. chapters for someone to visit him. Such a request was met with ridicule as well as refusal. In our planning for the rehabilitation of the alcoholic such a request is handled by a patient A. A. member rather than one from an in-town group.

The acknowledgment that Alcoholics Anonymous has effectively handled the rehabilitation of the alcoholic needs no additional verification. It is important to realize that this is accomplished on a 12-step program set up on a mental hygienic basis. After much consideration the Veterans Administration Hospital, North Little Rock, Arkansas, petitioned the National Alcoholics

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Anonymous Foundation in New York City for permission to establish a hospital group. The granting of such a request presented the hospital with the opportunity, or perhaps one should say the challenge, of integrating the alcoholic patient from his first day in the hospital into the A. A. program. It was recognized that A. A. must be developed early in the patient's hospitalization as an unequivocal need. That such a need would have to be nurtured postulated a concentrated community retraining period² that would ensure the patient's acceptance and continuation of A. A. principles upon being discharged from the hospital.

Now, following a year's efforts there has been evolved one therapeutic approach for the treatment of the alcoholic. Its merit lies not in its uniqueness but rather in recognizing that the responsibility of the hospital does not stop when the patient is discharged. It continues until civilian rehabilitation is assured.

It is not our intention to present an infallible procedure. Our "failures" have not been buried but are, undoubtedly, uncorking liquid fantasies at this very moment. On the other hand, during a one-year period 190 patients have been exposed, by their own desire, to this program. Of that number only 19 have been readmitted as a result of excessive alcoholism. The status of veterans does not permit a follow-up study, which would probably reveal a few who have "slipped" and are in other hospitals or correctional institutions. (This does not sell short the value of the local A. A. chapter. In the over-all program the contributions of the local chapter may be evaluated positively since it is projected that the patient's need for A. A., as begun in the hospital, is accepted on a community level and effectively handled at that level.) Letters, comments relayed to the hospital, and personal contacts from A. A. chapters throughout the area served by this hospital attest to the rehabilitation of these former patients.

This therapeutic regime was accomplished not by fiat but by a progressive hospital administration that sponsored facilities for such

a program. A special room was furnished with chrome lounge chairs, a desk, and appropriate paintings, for the sole gathering of the A. A. group. But the keynote of this program is not the physical accoutrements but rather a patient-run A. A. group.

Upon being admitted to the hospital, the alcoholic patient, if accessible, is oriented to the routine of the hospital and is told of the hospital's A. A. group. An invitation to participate in this program is extended, but it is also explained that participation is strictly voluntary. The severely physically debilitated individual is extended an invitation when his physical condition permits. The active members take it upon themselves to recruit new patients, and encourage hesitant patients (sometimes without respect to diagnosis). This has led to signs being posted on the admission wards that read as follows, "A. A. Welcomes All Those with Alcoholic and Other Problems." (A later paper will describe the effectiveness of such group activity where individuals who have affective disturbances other than alcoholism have been encouraged to attend by A. A. members.)

Six days a week at a designated time this group meets for 1½ hours. One night a week those who are interested are taken to various city A. A. groups where they meet, among others, former members of the hospital group now successfully employed and who are enjoying reasonable emotional security. At all daily and night meetings the senior author is present.

The meetings follow the standard procedure of any A. A. group. The group elects a chairman and a secretary from its members. The chairman exercises the power of his office as though he were not a patient. It is interesting to note that on occasions the chairman has requested participating members to retire until such a time as they would be better able to work constructively in a group. On one occasion the group exercised its democratic prerogative by suggesting that the chairman retire until he was more emotionally able to hold the position. The secretary, contrary to the usual verbal Gregg abbreviations to which we are so well accustomed, is asked to relate, with as much detail as possible, the previous day's discussion.

² Harold W. Sterling, M.D., Manager of the Veterans Administration Hospital, North Little Rock, Arkansas, *The Community Plan*.

There is more to it than just such an A. A. group. The presence of a dynamically oriented therapist introduces a type of group psychotherapy not possible in the average group. It is important to remember that each participating member is responsible for his past behavior and that the eventual understanding of himself denies the necessity for furthering alcoholic experimental indulgences to attain the nirvana of irresponsibility. Rather than using the therapists' words to describe what is being done, for such would be basically biased, let us turn to the minutes of several secretaries during this past year.

As in all things, failures are inevitable. The lapses but stress the successes and the necessity to understand and thereby control ourselves. With these conclusions, the meeting considered marital relations with the particular case of belligerence toward the wife because of a feeling of insufficient demonstration of love from her—a condition rooted in a father-son relationship years previously. The denial of father's love was expressed in an almost unwarranted aggression toward the wife. We don't need to apologize; understanding is adequate repentance. Shame is but a reticence to face the facts.

Apologies, it was found, are shields, social protections, that mask the reasons behind impolite actions. They are in effect an excuse to hit someone without getting hit back. Accidents are akin to apologies—their high incidence rate among the same individuals, as evidenced by insurance company records, supports a subconscious foundation in accidents.

After the reading and approval of the minutes, discussions began with the analysis of specific incidents leading to emotional variances in several of the members. Almost everyone thinks he is normal, yet his case is unique. We find common ground when this barrier is pierced, and we understand that although no cases are identical, we all have similar problems with the same alcoholic outlet. Events don't happen; we make them happen. What we feel without senses is all of experience. Revenge was discussed as cutting someone else down to size and as retribution for a feeling of a former conscious or subconscious hurt.

When a difficult situation arises, our inability to face the problems gracefully indicates there is yet a lot about ourselves we do not understand. We may think we have arrived at peace with ourselves but an external pressure can remove the false shell of well-being and show us the doubts we have retained. Often we feel that we are angry at the medical profession instead of assuming the healthier attitude of realizing that the doctor's life is dedicated to our recovery. There is an emotional block in any reticence toward the doctor.

The popular excuse of being chained by a rural environment was blasted as inadequate. An example was made of the very real yoke of being a Negro in the south, and the successes of Lincoln and

Christ. There is no longer a wall between city and country—the advantages are available to all. When we buy a "poor devil" with delirium tremens a drink, we feel we're making an investment in our own future failure. It's a case of "Come coward, take a coward's hand. Let's walk that mile together." It's merely vicarious self-pity. Here we return to the vital self-understanding. We're different because we react differently to like stimuli. The doctor can speculate but needs the patient's assistance in verifying the emotional grounds for drinking.

A husband, it was thought, could be jealous of his own children for coming between himself and his wife and also because the husband envied the children's position of dependency and love. Often this jealousy is exposed in an unwarranted irritation caused by the children's activities. Time and financial necessity limit our medical assistance but we can further our self-inventory after we leave the hospital. When we have gone home we can find someone to whom we have no blood or emotional relations with whom we may compare and discuss problems, thus gaining perspective in our insight.

The subject of discussion today was to try to determine the reason for the action of the paying of a debt which never occurred and why the recipient never questioned it.

The following answers were generally accepted as the most appropriate:

1. We cannot correctly interpret another person's reaction in accepting and what disposal he made of the money.

2. That the matter should not be dropped with the statement that it was due to confusion as there is always a reason for every action.

3. The reason could be a test of honesty tried on the recipient or of appeasement by the giver.

4. That the true cause may be an underlying one totally different from what appears on the surface.

Discussion was opened by the reading of the tenth step of A.A. by one of the members, with his making an inventory of himself to determine the reason for his hospitalization and drinking. Through this inventory and views of other members these conditions were found to exist: A personality accustomed to taking his problems as a child to its mother, who receives him with warmth and understanding, will in later years expect this same understanding from his wife and when the individual does not receive this attention he is likely to use alcohol as a means to this end. The same is true of a person who has had very little affection or none at all as a child. He tends to seek this affection he would have liked to have had as a child, from his wife. If his wife doesn't satisfy this desire for understanding and affection he will seek it elsewhere.

From Saturday meeting further discussion was carried on by the group as to why we evade the direct answer to certain questions. It was brought out that our every thought comes from somewhere and we just don't do things without thinking. In getting along with people the secret lies within ourselves. Whether our actions come from conscious or unconscious material within ourselves we are

responsible. We confuse ourselves by repressing thoughts rather than bringing them out in the open. It was brought out that we are different every day because things and thoughts differ each day.

Although the superficial insight gained in the above psychotherapy is felt to be of definite importance in patients' improvement, it is also realized that the alcoholic patient's great need to make an attachment to someone or some group must be met. One of the aims in the A. A. program in this regime is to transfer the patient's attachment from the hospital group to local A. A. group. Occasionally this creates a problem when a patient becomes too closely attached to the hospital group and cannot accept severance from it. This is seen when a discharged patient becomes upset and asks the therapist to intercede with the admission officer when hospitalization is not indicated. This is met with realistic understanding and the patient is told that he must observe the regular channel of admission. This often results in a "spree" followed by a reuniting with his local group and doing well. On this same basis, during hospitalization demands for unneeded sedation are met with kind and understanding refusal. This situation was discussed intensively by the group one morning as a result of a complaint by a new member that he was not receiving needed sedation. The group as a whole agreed that sedation following a spree was equivalent to taking another drink and prolonged the sobering-up period. They felt it was better to suffer a little more for a shorter period by not taking medication. It was the opinion of the group that the doctor should be the sole judge as to the need of sedation after a prolonged bout of drinking and that he should not be swayed by the pleadings and threats of the patient who by the nature of his illness will demand excess sedation.

The personality of the therapist is important if this necessary attachment is made. No latent hostility toward alcoholism can exist in a therapist if he is to be successful in a program of this type. He must also be flexible enough to accept any hostility from the patients or any uncompromising colleagues. The limitation of the number of hours to be spent with the alcoholic patient is not conducive to a successful program. Emotional

crisis may occur at any hour and the presence of the therapist at that time may make the difference between success and failure.

This does not imply that the alcoholic patient is deprived of the other services in the hospital. In reality Alcoholics Anonymous is but another adjunct to the over-all treatment program, which includes many activities such as corrective, educational, occupational, and physiotherapies as well as individual psychotherapy as indicated.

In summary, this procedure is not offered as a "cure" but rather as one hospital's approach to the perplexing as well as persistent alcoholic dilemma. It is further realized that the need to continue with Alcoholics Anonymous following discharge from the hospital is of paramount importance. This assistance is amply offered through local A. A. chapters where examples of rehabilitation are continuously available to the recently hospitalized alcoholic patient.

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CARDIAC EPILEPSY SIMULATING THE ANGINAL SYNDROME

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A case of apparent cardiac epilepsy is reported, demonstrating all the cardinal characteristics of clinical anginal syndrome.

CASE

A 39-year-old well-developed, well-nourished white male consulted a cardiologist because of recurrent attacks of substernal pain precipitated by effort, excitement, heavy meals, of 4 months' duration. The pains occurred usually 2 or 3 times a week, approximately an hour after the evening meal, lasting 20 to 30 minutes. The onset was sudden and paroxysmal with marked cardiac distress, accompanied by morbid fear of death. The pains usually radiated to the left shoulder, arm, and fingers and did not respond to the usual vasodilators.

Careful studies by the cardiologist, including an electrocardiograph (Fig. 1), revealed no abnormalities. Blood count, urinalysis, blood Wassermann, blood chemistry were all within normal limits. Because of the consultant's suspicion that the basic trouble might be psychoneurotic, he was referred to the neuropsychiatrist for an opinion.

Careful studies revealed no neuropathic traits. The family history and past history were essentially normal. The patient apparently had been in good health until onset of present symptoms. Preceding each attack a peculiar feeling of nausea occurred, lasting a second or two before the sudden paroxysmal substernal pain; when the distress subsided, patient felt completely exhausted for about 2 hours. Because of history of aura, the episodic irregular character of the attacks, the sudden onset of paroxysmal pain, the cardiac distress, and the exhaustion following the attack, it was assumed that possibly a cerebral dysrhythmia existed. Using a 4-channel electroencephalograph, both monopolar and bipolar readings were taken. The EEG revealed high voltage, slow abnormal activity in both cerebral hemispheres (Fig. 2). This pattern was markedly built up after 2 minutes of hyperventilation (Fig. 3) and was characterized by showers of high voltage, fast activity in all leads. Because of a suspicion that the attacks might be epileptic, the patient was put on a trial of dilantin sodium, grains 1½, three times a day. For the next 2 weeks he had no recurrence of the attacks. The EEG was repeated at the end of this period (Fig. 4); the pattern was normal throughout. At the end of the third week the dilantin was discontinued, and the EEG repeated 48 hours later (Fig. 5). Again the record became abnormal. Three days later when the patient was placed on anticonvulsive medication, the EEG returned to normal (Fig. 6).

DISCUSSION

Recently, Segal and Blair reported EEG findings in 104 cases manifesting gastroin-

testinal symptoms with no evidence of lesions. Approximately 70% of the EEG studies were found to be dysrhythmic. Dramatic improvement occurred in all cases after institution of anticonvulsive medication.

Moore has demonstrated the existence of abdominal epilepsy as an entity. Although this syndrome he considered not uniform, he believed that it had as its nucleus paroxysmal abdominal pain preceded by an aura of nausea, vomiting, diarrhea, pallor and sweating, and palpitation without loss of consciousness. He gives 4 criteria for the diagnosis of abdominal epilepsy: (1) periodicity of irregular episodes, (2) sudden onset of pain, (3) paroxysmal nature of the pain, and (4) abdominal distress and positive EEG findings. The case discussed above falls within this category.

It is assumed that the mechanism in the production of cardiac epilepsy may have the same basis as that of abdominal epilepsy.

SUMMARY

A case of apparent cardiac epilepsy is presented with electrocardiographic and electroencephalographic interpretations.

It is hoped that further studies may be carried out in order to demonstrate conclusively the existence of cardiac epilepsy as an entity.

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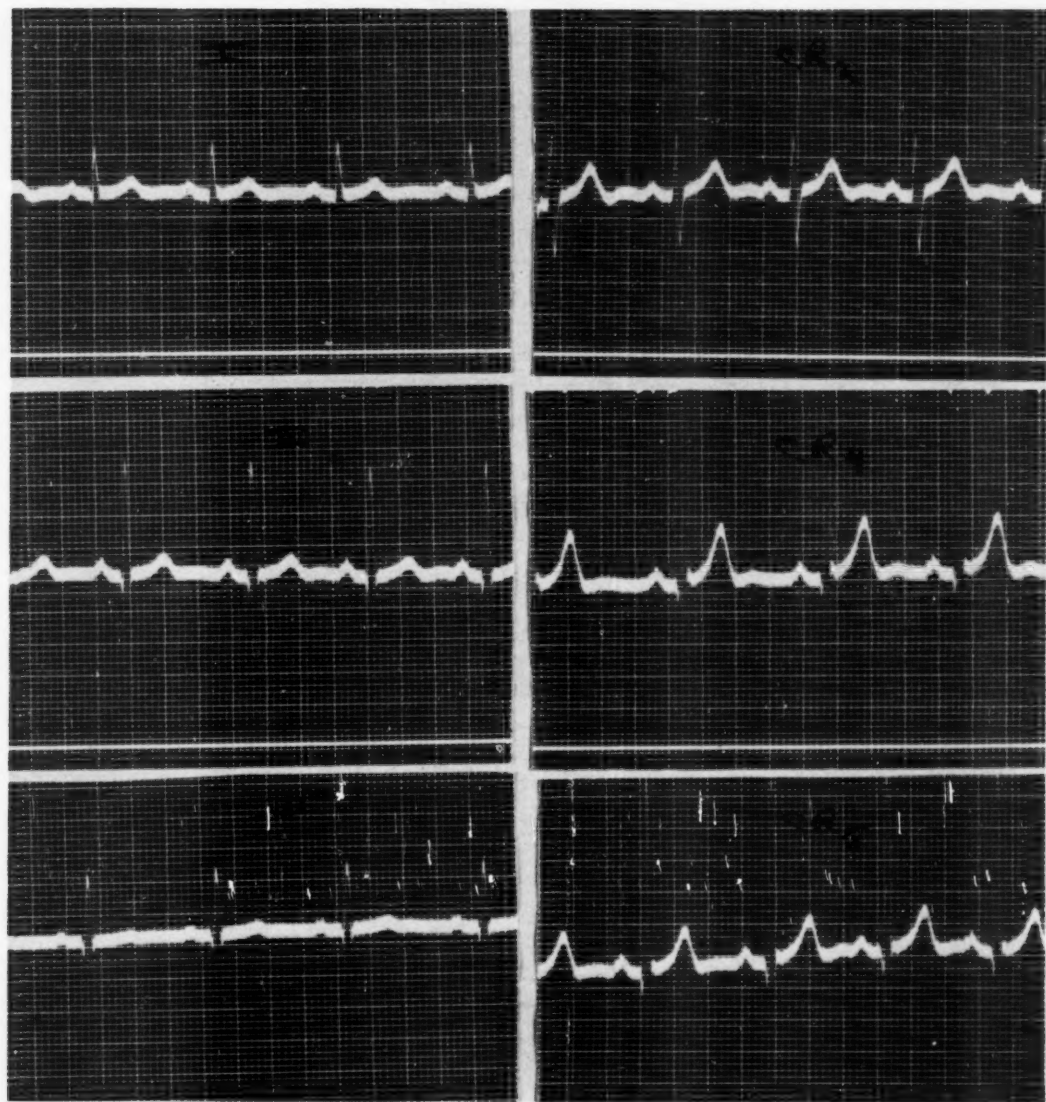


FIG. 1.—Initial electrocardiograph.



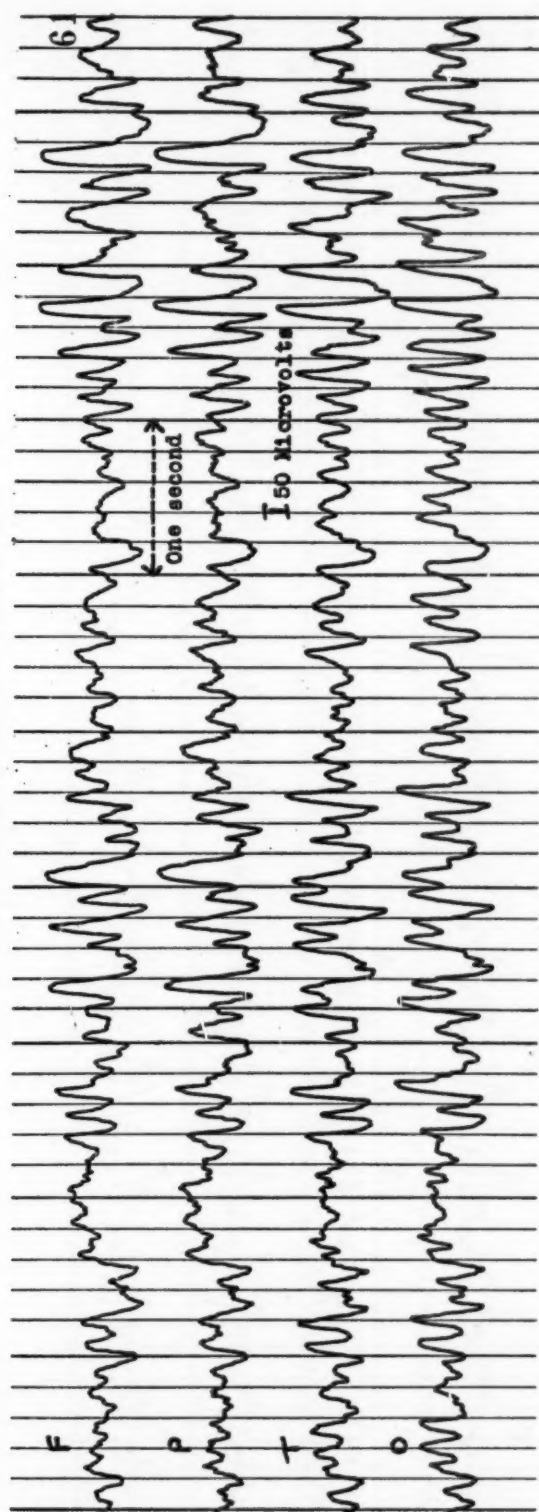


FIG. 2.—Initial electroencephalograph.

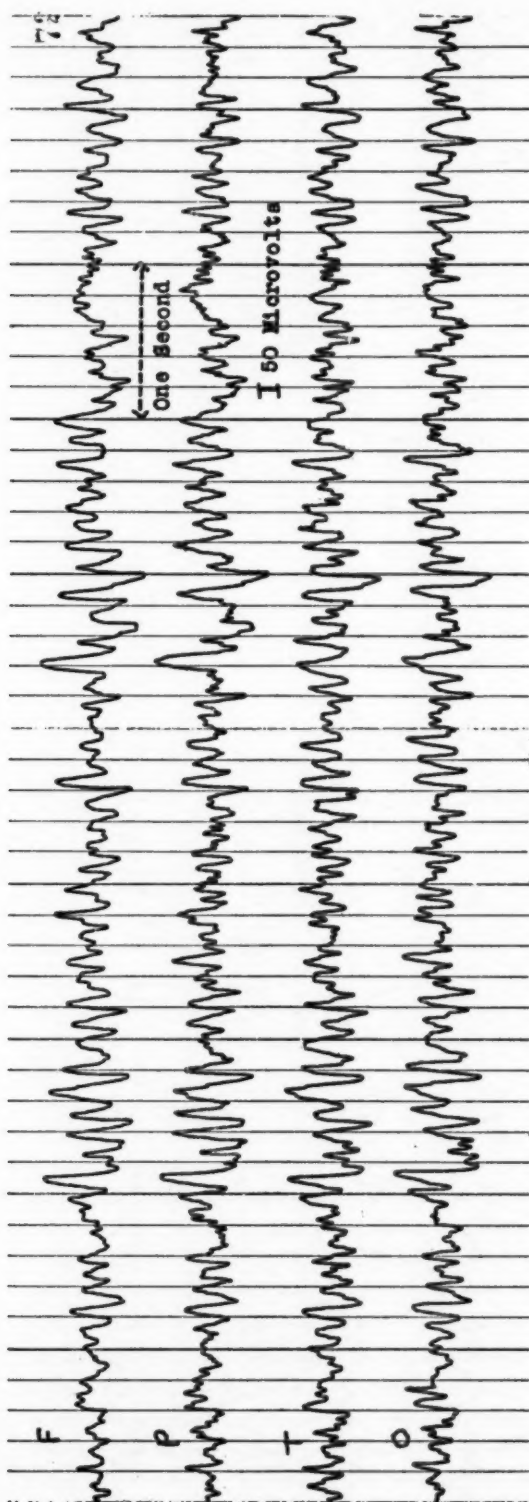


FIG. 3.—The EEG after two minutes of hyperventilation

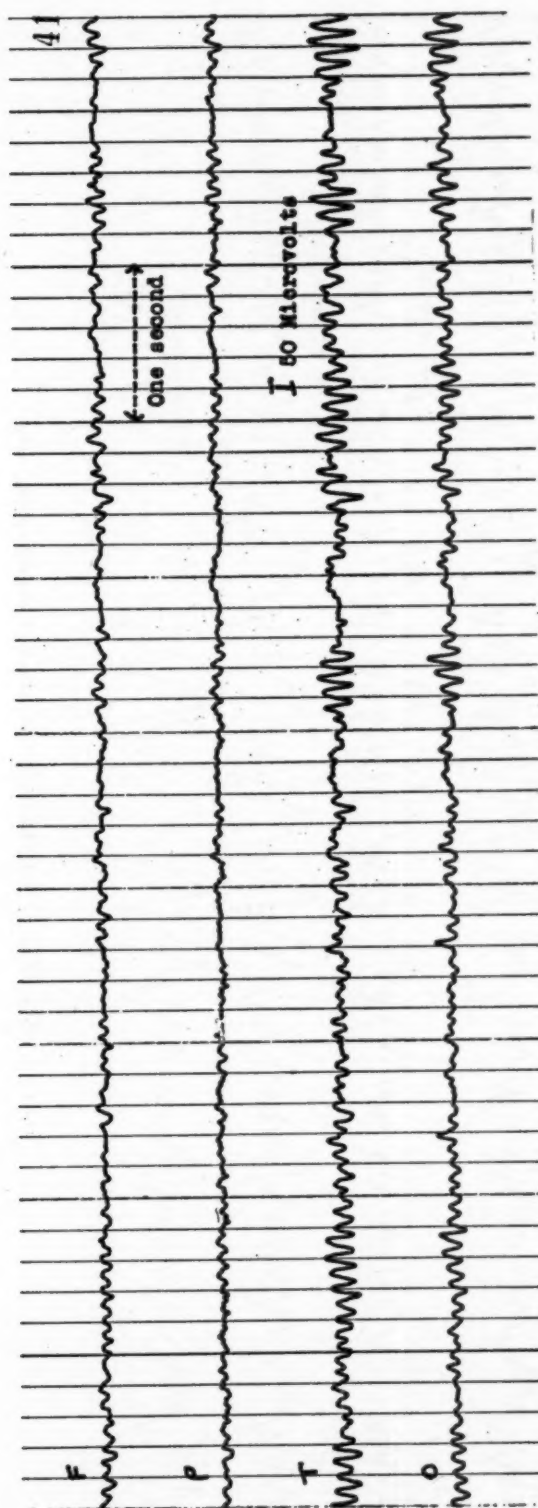


FIG. 4.—The EEG two weeks after dilantin therapy.

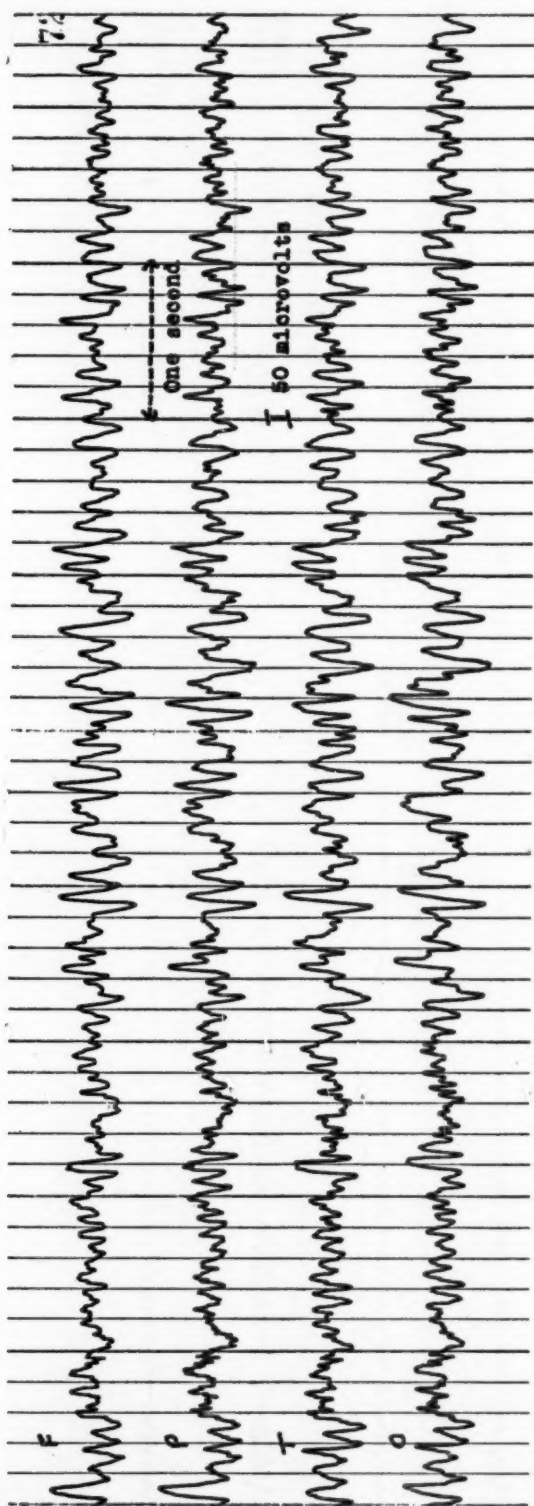


FIG. 5.—The EEG 48 hours after discontinuance of anticonvulsant drug.

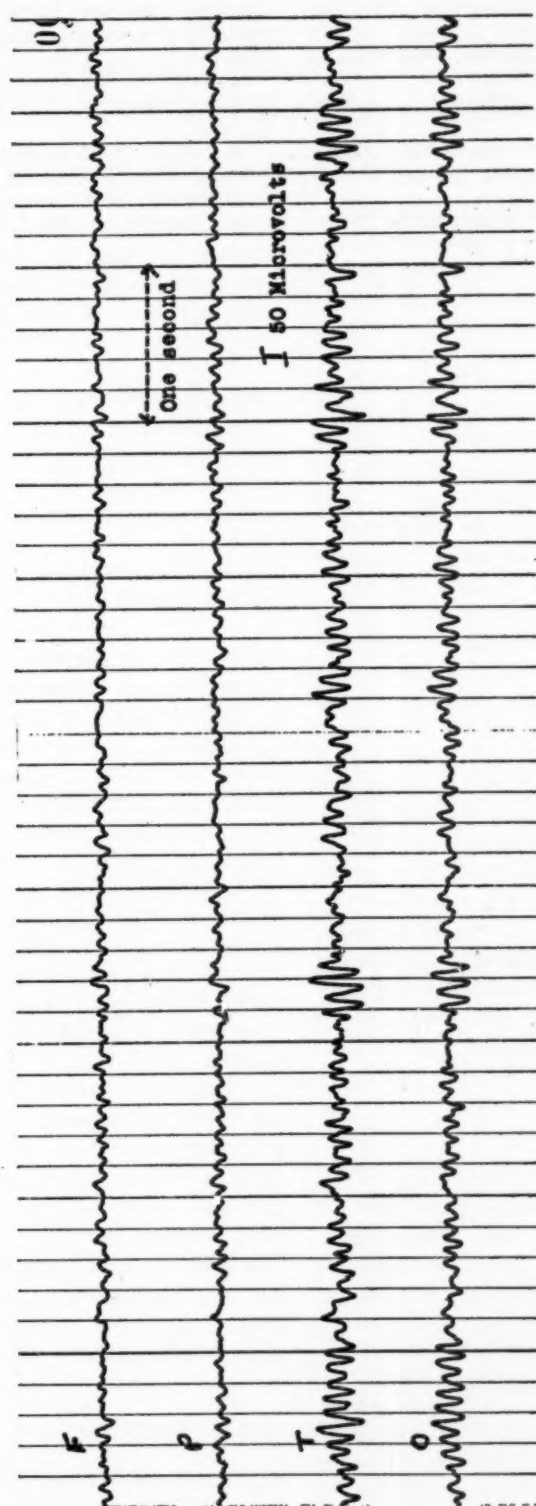


FIG. 6.—The EEG three days after resumption of dilantin.

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A COMPARATIVE STUDY OF THE AMNESTIC SYNDROME IN VARIOUS ORGANIC CONDITIONS¹

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The following preliminary study was undertaken with the object of investigating the individual characteristics and similarities of the amnesic syndrome found in patients following bilateral prefrontal lobotomy and electroshock therapy, and in those suffering from senile and alcoholic Korsakow psychoses.

We are using the general term amnesic syndrome to indicate that the individual components constituting such syndromes, like retro- and anterograde amnesia, retention defects for recent and remote memories, impairment of immediate recall, disorientation, and confabulations, may be present to a different degree in the various clinical entities and in individual patients.

Four groups were selected for our study. The first group comprises 10 cases of senile dementia (average age 78), the second, 10 cases of alcoholic Korsakow (average age 51.5), both presenting the amnesic syndrome typically found in these diseases. The third group includes 10 cases of functional psychoses—schizophrenia or manic-depressive psychosis (average age 39.9) treated with electroshocks. These patients were examined before treatment and then at regular intervals during treatment. The fourth group is made up of 8 cases of functional psychoses in whom bilateral prefrontal lobotomies were performed (average age 32.4). Five of these cases were examined repeatedly during the first 10 days after operation and at longer intervals after that time. The 3 remaining lobotomy cases were studied at intervals ranging from 1-2 years after operation. A group of 10 control cases of normal hospital personnel (average age 29.2) was included and examined repeatedly to get a base line for quantitative comparison with the other groups and to study the practice effect of our tests.

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METHOD

The methods used were clinical observation, a modified Wechsler Memory Scale (1), and Meyrat's test of partial memories (2). Regarding Wechsler's scale the following subtests were used: (1) orientation, (2) personal and current information, (3) immediate recall of logical material, (4) digits forwards, (5) digits backwards. Some of his subtests were omitted in order to avoid a tiring effect, since 3 additional tests were added: tests of recent and remote memory and the presentation of 5 objects to be recalled after asking an unrelated question.

Meyrat's test is based on the author's assumption that mnestic functions are part of the functions that they sustain and that therefore amnesic disorders are but a combination of disturbances of partial memories. Although we do not want to discuss Meyrat's hypothesis at this point, we found his method useful for our study.

The patient is asked to recall and reproduce either verbally or in action the stimulus given, at intervals increasing from 10 seconds to 2 minutes, up to a total period of 5 minutes. Eight such stimuli were used. These were: a meaningless syllable, a meaningful word, an action to be reproduced verbally, an action to be reproduced by the same action, a certain location in space, a written word, a painful sensation, and a stereognostic experience.

RESULTS

We shall report first on the findings with the different groups of subjects.

Regarding the control group no signs of memory impairment were evident either on clinical examination or with our tests. It should be mentioned, however, that on Wechsler's test for immediate recall of logical material only 1 member of the control group was able to achieve a full score and even that only after some practice effect had taken place. The other control subjects had lower scores on this particular test, but these differences were statistically not significant.

Our senile group showed clinically all the essential features of a senile amnesic syndrome, although it was present to a varying degree in the different patients. There was disorientation, loss of memory for recent and remote events, and severe impairment of immediate recall. Confabulations were present in some but not in all members of this group.

In the psychological tests our senile patients taken as a group had scores that were without exception very significantly lower than those of the controls. This applies not only to the subtests of Wechsler's memory scale but also to Meyrat's partial memory test. In fact it should be mentioned that the seniles were the only group that had a significantly lower score in the latter test. All the other groups had scores either the same as or not significantly lower than the controls.

Another interesting feature of the results from the Meyrat test is that there was no uniformity between its different subtests. A patient, for instance, would reach a full score on repeated verbal memory as measured with this test, but a score of zero for recall of a written work, and vice versa. There was furthermore no patient in this group who could not recall at least once, that is after 10 seconds, a painful stimulus and even locate it, and some of our senile patients achieved a full score on the pain subtest. No practice effect was recognizable with these different subtests, although they were repeated after short intervals. We feel, therefore, that Meyrat's test occupies a special place among the memory tests at least as far as our senile patients are concerned.

Our alcoholic Korsakow group demonstrated the well-known clinical characteristics of this syndrome. There was disorientation in all 3 fields, defect of recent and remote memory, severe impairment of immediate recall. Some patients showed confabulation. As far as the clinical aspect of the amnesic syndrome *per se* is concerned there are therefore no essential differences between the senile group and the alcoholic Korsakow group. Accordingly we found no essential differences between these 2 groups in our psychological tests, apart from the fact that the Korsakow group made somewhat higher scores. The only remarkable exception was Meyrat's partial memory test. There the Korsakow group achieved a score considera-

bly higher than the seniles, a difference that proved statistically very significant. In conformity with this finding there was no significant difference between the Korsakow's and the controls. In the Korsakow group there was furthermore no lack of uniformity between the subgroups of Meyrat's test, as was seen in the senile group.

Considerable literature has accumulated regarding the memory impairment after electroshock treatment. This has been extensively reviewed by Kalinowsky and Hoch(3) in the 1952 edition of their book on shock treatment and psychosurgery. These authors point out that the psychic changes that occur after a series of electroshock treatments have to be differentiated from those occurring after a single shock. In the latter respect they state that the behaviour of different patients after a single electric shock may vary but remains fairly constant during the treatment, as far as the individual patient is concerned. They stress the disorientation in time, the loss of familiarity of perceptions, and they agree with most of the authors that the retrograde amnesia found in some patients usually shrinks. After several shocks "organic psychotic reactions" may develop. The most constant sign of this is impairment of memory. There is so far no proof that these reactions are permanent. As far as Bodamer's(4) "retropsychotic amnesia" is concerned, that is, the amnesia that occurs in some patients for the whole psychosis for which they have been treated by means of electroshock, Kalinowsky and Hoch state that there is no uniformity in the findings and no valid conclusions can be drawn as to its nature and origin.

Two other important papers should be mentioned here. Häfner(5) in 1951 reported from the clinical point of view on the experience of the psychiatric clinic in Munich. He states that the organic shock syndrome occurs only after repeated electroshocks and particularly after the so-called block treatment widely used in Germany. An amnesic syndrome—with disorientation, antero- and retrograde amnesia, impairment of recall—forms the core of the organic shock syndrome, but it is accompanied by clouded consciousness, apathy, impairment of thinking, and perplexity or anxiety. It is only after several days that these features disappear and

the amnesic syndrome becomes plainly recognizable. Häfner states that severe amnesic disorders may remain present for long periods particularly after block treatment, and in elderly people. He recognizes the occurrence of retropsychotic amnesia, agrees with its good prognostic significance but denies, in contrast to Bodamer, its organic origin.

Hetherington(6) tried to measure the psychological changes due to electroshock treatment by a battery of tests given repeatedly to 10 patients before, during, and after treatment and to an equal number of normal controls at weekly intervals. As far as memory functions are concerned, Hetherington could confirm the findings of previous authors that electroshock treatment impairs both recognition and recall of material assimilated before. Recall was affected more than recognition. He brings forward evidence that it is assimilation rather than retention as such that is affected by the treatment.

Our own clinical observations showed the following: Our patients had a brief retro- and anterograde amnesia for the individual shock. The retrograde part covered a period immediately before the shock that varied with the individual patient. In some this extended from the time they were put to bed or received the injection of curare. Others remembered events up to the point where the electrodes were applied. The anterograde part covered the seizure itself and a short period afterward during which patients were confused and disoriented. We also can confirm Kalinowsky's and Hoch's statement that the behavior of the individual patient was always the same after the individual shocks. A severe organic shock reaction was not observed among the patients referred to. This difference is probably due to the fact that no block treatment was applied in our material.² We observed in one case a retropsychotic amnesia in the sense of Bodamer. On questioning this patient, we found that he had completely forgotten about his psychosis, the suicidal attempt that brought him into the hospital, and even about the marital conflict

that had precipitated his breakdown. However, in contrast to Bodamer we may state that this retropsychotic amnesia had all the features of a psychogenic amnesia.

Regarding the psychological tests: before treatment was started our ECT cases showed test scores identical with, or not significantly lower than, the controls. After treatment was started a steady loss in scores occurred in the tests for orientation, recent memory, and immediate recall. (Remote memory was less involved.) This loss continued up to the sixth shock. After the sixth shock the scores either remained constant or there was even a rise. This fairly regular trend did not apply to 2 of our tests. Our ECT patients had, before treatment started, a significantly lower score for recall of logical material. This was probably due to their psychotic preoccupation. During treatment the score on this test went up until it reached a certain peak although it still remained significantly lower than the test scores of the controls. This peak was usually reached between the third and the sixth shock. It was furthermore interesting that no practice effect took place after that time, while such an effect was clearly visible with our control patients who had not reached a full score on this test in their early trials.

The other exception from the usual trend was the partial memory test of Meyrat. Our ECT patients had normal test scores before treatment started and these remained unchanged during the whole observation period.

Summing up our experiences with electroshock therapy as applied at our hospital, we may state that we did not observe the severe organic shock reactions described by German authors. The memory impairment that we could observe in our patients was quantitatively considerably less pronounced than that seen in the amnesic syndromes of senile and alcoholic patients and it was found to be reversible.

The psychological changes after bilateral prefrontal lobotomy have been studied extensively by many authors. Freeman and Watts (7) point out that their patients, for several days after lobotomy, showed a confusional state with disorientation in all spheres particularly in time, confabulation, and denial of the operation. There was accompanying alternating restlessness and inertia. They at-

² Our method involved the use of one ECT given on alternate days. The average amperage used was 600 ma's and this was applied for 0.5 seconds in practically all cases. Fifty to sixty units of d-tubocurarine were injected intravenously 2 to 3 minutes before the treatment was given.

tribute this syndrome to postoperative diaschisis. Only after this immediate postoperative picture cleared did a period of frontal lobe deficit become observable. During this latter period their patients showed mainly lack of initiative and concern, whereas intelligence was satisfactorily preserved. While there was, not infrequently, postoperative amnesia, they found that memory function as such did not seem to be gravely affected.

Malmo(8), on the basis of his animal experiments, where the frontal association areas were removed bilaterally in a group of monkeys, found that these animals had a decreased capacity to remember because they were more susceptible to retroactive inhibition. In dealing with human subjects after bilateral frontal gyrectomy and bilateral frontal lobotomy, Malmo(9) came to the conclusion that there was a slight drop in general intelligence and a tendency to greater concreteness of definition, both not related to the extent and location of the removal of brain tissue, but explainable by a reduction of the patient's ability to maintain a set in the face of interference.

The most recent contribution to the problem in question was made by Klein(10) in his investigation of the immediate effects of leucotomy on cerebral function of patients at the Crichton Royal Hospital. He distinguished 2 groups of symptoms in the postoperative period, those that may be present and those invariably present. Among the latter he mentions the amnesic syndrome, disorder in time, discontinuity of the preoperative ideation, and lack of curiosity. The amnesic syndrome itself consists of a retention defect characterized by susceptibility to distracting stimuli, and a very short span of memory. There is furthermore antero- and retrograde amnesia that is independent of the lowering of the general intellectual function.

Our clinical findings with the lobotomy patients were the following. In the postoperative period there was always an amnesia with a retro- and anterograde component. The retrograde amnesia varied in our patients from a few hours to 1-2 days. Although it was difficult with our psychotic patients to define a sharp limit to the retrograde amnesia, it was possible to establish its duration at least up to a certain point. Shortly before the operation it was carefully established that the

patient was aware of the fact that his head had been shaved 24 hours prior to operation. In the immediate postoperative period both the interview and the fact that the patient's head had been shaved were forgotten. Some of the facts covered by the retrograde amnesia later on became available to the patient, probably on the basis of clues. The anterograde amnesia covered not only the period of anaesthesia and unconsciousness following the operation but a period lasting from several hours to one day. Events during this period remained totally unavailable to the patients. In the first postoperative days the patients showed disorientation in all 3 fields, but particularly in time, and a considerable impairment of immediate memory. Confabulations were noticeable, particularly regarding the patient's explanation for the presence of dressings on the head. A constant finding was the patient's denial of the operation, even after being told of it. There are several possible reasons for this. First is the fact that the operation itself was included in the period of total amnesia. Then there would be the marked impairment of recent memory, which would cause the patient to forget the fact of having been told that an operation had been performed. It should be noted, however, that other material was not as easily forgotten. This tends to indicate that a psychodynamic factor may be involved.

Turning now to our test results obtained during the first 10 days after operation, we find lower scores in all subtests of the modified Wechsler memory scale. The least affected were the digit spans. The most affected was the recall of logical material. No significant lowering of the scores was obtained with Meyrat's partial memory test. However, there were 2 patients who had a lower score with this particular test, both of them in the verbal repetition of an action and one also in the verbal repetition of a written word. The results indicated that no practice effect occurred with the repeated recall of the stimuli in these 2 patients. It should be noted that there was no diminution of recall of painful stimuli, although lobotomies have been effectively applied in the treatment of intractable pain.

The findings in our lobotomy cases after the postoperative period had passed showed a general increase in score, both in the total and

in the individual subtests. However, our findings indicated a persistent defect of recent memory, even in cases where testing was done as long as 2½ years following operation.

DISCUSSION

Comparing the 4 amnesic syndromes investigated, we find in 2 of them, in the seniles and the alcoholic Korsakow psychoses, impairment of remote memory more pronounced in the senile group, but we did not find in these 2 groups the circumscribed gaps of memory, clinically called amnesia s.str. On the other hand, in the 2 groups, the lobotomy and the electroshock patients, there was amnesia, retro- and anterograde, but there was no gross impairment of remote memories; if there was such a defect it could be detected only with finer tests.

All 4 groups presented considerable impairment of recent memory and immediate recall both clinically and with psychological tests. This formed a striking feature of the psychopathological picture in all 4 conditions. If one takes into consideration that impairment of recent memory and immediate recall is also found in a number of other organic conditions not referred to here, like brain injury, strangulation, carbon monoxide poisoning, G.P.I., and Alzheimer's disease, one arrives at the conclusion that this type of memory impairment is the most common one as far as organic brain diseases are concerned. In other words, that phase of the process of remembering that functions in the recording and assimilation of new experiences and its underlying mechanism seems to be the most vulnerable.

From the psychopathological point of view our understanding of this interesting fact is greatly helped by Cameron's (11) concept of memory as reactivity. If we regard recording as part of the primary reaction of the organism to an incident, then it would appear that all the factors that modify such a reaction would influence recording.

In the case of organic brain damage, many factors may modify the primary reaction. Location of the lesion or process, however, seems to be an important factor.

Knowledge is accumulating that there is in the brain a system, the function of which seems to be connected with recording. Pen-

field (12) in stimulating the temporal cortex was able to evoke in his patients recollections of previous experiences, which by their vividness resembled present experiences. In discussing the stimulation effects on the temporal lobes, Penfield arrives at the assumption that an integrating system, located in the higher brain stem and connected with both hemispheres, a centrencephalic system, is involved in the mechanism of recording. Only from here could the recording nerve impulses be projected to the temporal cortex of each side. The functional importance of such a system in the brain stem for cortical activity becomes clear from the work of Jasper (13), and of Magoun (14), and their co-workers.

Neuropathological observations are on record that seem to have considerable bearing on the problem in question. Gamper (15) investigated the brains of younger patients who had suffered from alcoholic Korsakow for only a short period of a few months. He found pathological changes qualitatively identical with those found in Wernicke's disease in a region extending bilaterally from the dorsal vagal nucleus cephalad to the medial part of the medial thalamic nucleus. The changes were most marked in the mammillary bodies, the posterior colliculi, and the central gray matter around the aqueduct. The cortex, on the other hand, was remarkably free from pathological changes. Gamper's observation was later confirmed by several authors (Neuburger (16), Környey (17), Almeida Dias (18) and others). Although the pathological changes reported by these authors varied qualitatively according to the underlying cause, they were located in the same region: the hypothalamus, mammillary bodies, and their neighbourhood. The latest contribution in this respect is the report in 1950 by Brouwer (19), who observed inflammatory changes confined solely to the hypothalamus and the mammillary bodies and accompanied by Korsakow's psychosis. Another observation made in 1951 by Conrad and Ule (20) concerns a case of necrotizing encephalitis involving bilaterally the hippocampal region with demyelination of both fornices and transneuronal atrophy of the mammillary bodies. This case also was mentally characterized by Korsakow's syndrome. It is interesting to note that French, Amerongen, and Magoun (21) reported just recently on an

activating system in the brain stem of monkeys occupying essentially the same region in which Gamper has found the pathological changes in alcoholic Korsakows—the mid-brain, tegmentum, the subthalamus, hypothalamus, and the medial portion of the thalamus.

In the light of these observations it becomes understandable that impairment of immediate memory may ensue in temporal and causal consequence of lesions that in their acute impact on such a system produce unconsciousness with antero- and retrograde amnesia. With subacute and chronic lesions and processes such an impairment of immediate memory may develop without being preceded by a phase of unconsciousness with circumscribed amnesia. It will be interesting to see whether processes involving both temporal lobes like Pick's disease and Lissauer's form of G.P.I. are accompanied by the same type of memory defect. It is even possible that processes with so-called diffuse involvement of the brain like senile dementia, Alzheimer's disease, and G.P.I. owe their defect in immediate memory to the involvement of the recording system in question. Detailed histological studies of the region involved will be necessary in these conditions.

However, one has to keep in mind that impairment of immediate memory also may be produced more indirectly by lesions with other locations that lead to a reduction in the patient's ability to maintain a set in the face of interference, as proposed by Malmo. Such could be the case with the impairment of immediate memory that we found in our lobotomy cases after the first postoperative days had passed.

Another interesting fact that emerges from our investigations is the results obtained with Meyrat's test for partial memories. We have seen that there was only one group that showed significant impairment in the latter test, as compared with the controls, this being the group of seniles. In all other groups this test was not significantly altered, although all our patients showed significant impairment of immediate memory. Other interesting facts concerning this test were that no practice effect took place and that the results obtained with its different subtests were completely independent of each other so that, for instance, a senile patient who could recall a word that

he had heard was not able to recall a word that he had read, and vice versa.

It would be too easy an explanation to say that the impairment of partial memories as reflected in Meyrat's test is due to the advanced age of senile patients. Such an explanation seems only to pose the problem in other words, for how does age influence memory? Certainly it must be via the brain and its functional mechanisms. It seems that in certain conditions like senile dementia and Alzheimer's disease there exists, in addition to the impairment of memory involving the person as an integrated whole, another kind of memory impairment connected with special functions. Such a concept has been repeatedly evolved in connection with observations on aphasia, apraxia, and similar conditions. It is usually believed that this type of memory impairment for special functions concerns mostly the phases of retention and reactivation. Our investigation shows that it may be operative already in the primary reaction, in recording. However, we cannot agree with Meyrat's assumption that the amnesic syndrome as found in senile patients is nothing more than the sum total of the defects in partial memories. Rather it forms only a part of the whole picture of the senile amnesic syndrome.

SUMMARY

1. The amnesic syndromes as occurring in senile psychosis, alcoholic Korsakow, after electroshock treatment, and after bilateral prefrontal lobotomy are compared both clinically and by means of psychological tests.
2. Impairment of recent memory and immediate recall has been found as the type of memory impairment common to the 4 amnesic syndromes investigated.
3. The theoretical implications of these findings are discussed.
4. Impairment of partial memories as tested with Meyrat's method has been found only in senile psychosis.

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AN OUTLINE AND BIBLIOGRAPHY FOR A SEMINAR IN CLINICAL PSYCHOLOGY FOR RESIDENT PHYSICIANS IN PSYCHIATRY¹

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The resident training program in psychiatry at the Veterans Administration Hospital, Coatesville, Pennsylvania, follows a definite curriculum. As originally planned, provision was made for instruction of residents in various aspects of clinical psychology during their first year of residency. The data here presented reflect experience with a clinical psychology seminar for the past 5 years and consist of the outline of the material covered and the bibliography used to support and augment the outline.

To a great extent the course has been the outgrowth of the suggestions of the participating resident and staff physicians. It has been given in weekly sessions following a brief intensive orientation period designed to help the residents begin to make effective use of psychological reports. Throughout the year case material is used in seminars and conferences.

Order of topics and degree of emphasis have varied to some extent depending on the interests and previous experience of the groups. This principle of presentation often sacrifices logical order to more complete comprehension. For instance, it was found that the nature-nurture controversy became more meaningful if it followed the unit on intelligence tests, though logically it might be better considered under the nature of intelligence. Similarly, a consideration of the historical development of clinical psychology might logically have opened the series but in practice it was more satisfactory to present it as a summarizing unit. There is, of course, much overlap in some of these topics, but this adds emphasis and makes possible presentation of the same material from various points of view.

¹ From the Veterans Administration Hospital, Coatesville, Pa.

PART I. OUTLINE

INTELLECTUAL FUNCTIONING

- I. The nature of intelligence
 - A. The concept of intelligence as a potentiality unfolding in the process of maturation (61)
 1. Relation to the total process of ego development
 - a. Concept formation and its role in forming the individual's private world and his patterns of reaction (18, 61, 69)
 - B. Theories of Spearman, Thorndyke, and Thurstone (75, 84, 85)
 - C. Cognitive and conative factors (88)
 - D. Statistical distribution (83, 86, 89)
 - E. The relationship between general intelligence and special aptitude and interest patterns
- II. Problems in judging intelligence
 - A. Factors that lead to underestimation of intelligence
 1. Confusion of mental deficiency with some types of mental illness or with personality patterns predisposing an individual to mental illness (38, 62)
 2. Reading and speech difficulties (56)
 3. Congenital deafness (65)
 4. Brain injury (77)
 - B. Factors that lead to overestimation of intelligence
 1. Intellectualizing as a defense mechanism (45, A Case of Chronic Anxiety; 61)
 2. The drive to live beyond one's intellectual means (47)
 - C. The need for objective standards of judgment
- III. Intelligence tests
 - A. The construction of intelligence tests, problems of reliability and validity (80, 83, 89)
 - B. Uses and limitation of group intelligence tests
 - C. Demonstration and discussion of individual scales
 1. Wechsler
 2. Stanford-Binet
 3. Gesell or Cattell Scales for infants

- D. Demonstration and discussion of tests of concept formation
 - 1. Color Form Sorting Test(25)
 - 2. Vigotsky Sorting Test(61)
 - 3. Hanfmann Kasanin Test(27, 61)
- E. Screening tests for mental deficiency that the psychiatrist can use
- IV. The nature-nurture controversy
 - A. Heredity and environment(91)
 - 1. The Kallikaks(21, 22)
 - 2. The Iowa studies(73, 74, 76)
 - 3. Schmidt's studies(39, 67, 68)
 - 4. Kallmann's studies on the genetics of schizophrenia(31, 34, 36, 57)
 - B. Effects of early emotional deprivation on children
 - 1. The Goldfarb studies(23, 24)
- V. Superior intelligence
 - A. Review of Hollingworth and Terman's studies(30, 81, 82)
- VI. Social and emotional problems related to mental deficiency
 - A. Criteria of mental deficiency(14)
 - B. Levels of feeble-mindedness(64, 86)
 - C. What social and vocational adjustment can be expected from the high-grade defectives(1, 90)
 - D. Psychotherapy with mental defectives(64)
- VII. Effects on memory, judgment, concept formation, and visual motor functioning of
 - A. Anxiety
 - B. Elation
 - C. Depression
 - D. Schizophrenia
 - E. Organic damage to the central nervous system

(These discussions are illustrated by test material produced by patients known to the group. Sufficient demonstration material is presented to give an idea of the wide range of differences in response within diagnostic categories)
- VIII. Changes in intellectual functioning following various types of treatments(20, 26, 33, 37, 40, 45, 46, 59)

PERSONALITY STRUCTURE

- I. The projective hypothesis(19, 61)
- II. Processes by which the individual structures his world
 - A. Association(61)
 - B. Perception and apperception
 - 1. Perceptual development demonstrated by the Rorschach records of children at various age levels(2, and selected records)
 - 2. Perceptual organization and the associative processes(61)
 - 3. The role of apperception in TAT responses; demonstration of selected records
 - C. Concept formation
 - 1. Discussion of the concept of the body image as developed by Schil-

der(66) supplemented by illustrations of the Draw-a-Person test(43) including productions of children of various age levels

- D. Fantasy thinking
- E. Introjection and projection(17)

- III. Projective tests
 - A. Historical development
 - B. Clinical validation, problems of validity and reliability
- IV. The personality as reflected in projective tests
 - A. The Rorschach test, hypotheses concerning the various determinants and the relationships between them(4, 61, 63)
 - B. The TAT, the needs-press hypothesis(54)
 - C. The Szondi test and Szondi's theories of personality(3, 11)
- V. Projective test protocols produced by patients who are
 - A. Anxious
 - B. Elated
 - C. Depressed
 - D. Schizophrenic
 - E. Suffering from various types of organic disorders of the central nervous system
(These discussions are illustrated by test material produced by patients who are known to the group. Sufficient demonstration material is presented to give an idea of the wide range of differences in response with diagnostic categories)
- VI. Changes in projective test results following various types of treatment(9, 26, 40, 45, 49, 60)

EXPERIMENTAL PSYCHOLOGY AND PERSONALITY DYNAMICS

- I. The conditioned response in personality development(42, 44, 50, 87)
- II. Experimental analysis of psychoanalytic phenomena(16, 70, 71)
- III. A stimulus response analysis of anxiety(52)
- IV. Learning theory and psychotherapy(15, 51)

HISTORICAL BACKGROUND OF CLINICAL PSYCHOLOGY

- I. Wundt and his laboratory at Leipzig(6, 29, 53)
- II. Edward Bradford Titchener(1867-1927). Psychology as pure science(5, 6, 29)
- III. William James(1842-1910). "He believed in the laboratory but he did not like it." Psychology as a natural science(6, 29, 58)
- IV. G. Stanley Hall(1894-1924). Pioneer in child study, education, and geriatrics. The introduction of Freud to America(6, 29, 53)
- V. John Dewey and his effect upon intellectual America. The progressive education movement(10, 12, 13, 28, 79)
- VI. Gestalt psychology and behaviorism(29)

- VII. Reactions of psychologists and psychiatrists to psychoanalysis (7, 32, 41, 55, 72, 78)
 VIII. The first psychological clinic, 1896(8)
 IX. Subsequent development of clinical psychology (48)

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MENTAL HEALTH AMONG THE SLAVE POPULATION ON SOUTHERN PLANTATIONS

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The status of the mental health of slaves on southern plantations was a controversial subject during the ante-bellum period. It was during this period that some beginning was made in the United States in the moral and humanitarian treatment of the insane as contrasted to the then current physical and legalistic approaches. Also our concept of mental illness was just beginning to change. In the South the presence of a large group of Negroes not long removed from a primitive society further complicated the mental health picture.

The Negro at this period may be classed as an uncivilized group that was competing against a higher civilization and was thereby being subjected to greater physical and emotional hazards with no opportunity to make adjustments as freedmen. The first statistics we have on mental health was the census of insane taken by the Federal Government in 1840. This report showed that the "insane and idiots" in the United States totaled 17,456. They were divided into 14,521 whites and 2,935 Negroes. In the North 1 out of 995 whites was listed as insane or idiotic. In the South the ratio for whites was 1 to 945.3. For Negroes the ratio in the North was 1 to every 144.5 persons, while in the South it was 1 to every 1,558(1). The discrepancy between the figures for the northern and southern Negro was too large to be overlooked, and in 1844 Dr. Edward Jarvis undertook to investigate the report of the 1840 census and his published report showed the numerous inaccuracies that had crept into the first census of the insane in this country (2). This census report was a great boon to the proslavery arguments by Southerners concerning the beneficial effects of slavery for the Negro. The abolitionists attempted to refute the arguments by following the lead of Dr. Jarvis in pointing out the discrepancies in the report. An account of this controversy has been ably discussed by Albert Deutsch (3).

We do know that the health of the Negro was of primary concern to the southern planter from both an economic and humanitarian standpoint. In fact the chief topics of conversation among planters were the weather, the crops, and the health of the Negroes. An account of the care and treatment of slaves by the planters has been discussed in another study (4). This is an attempt to evaluate their mental health. Additional material for the study of this problem was brought to light from an examination of planters' records and particularly from an examination of the inventory and appraisement records filed in the Probate Court Proceedings of southern counties. By way of explanation it may be added that in the settlement of any estate slaves, being property, were inventoried and appraised. If a slave had a physical disability or chronic illness it naturally affected his appraisement value since he could not do the work of a prime hand. These disabilities were included along with his appraisement value in the slave record.

The southern planter was faced with an economic problem in managing his estate. There was always a large group of Negroes who were nonworkers and had to be cared for. This group included the children and the old or infirm and might include as many as one-third to one-half the Negro population. It was essential for the profitable management of the plantation that everyone who could be employed be assigned some gainful task. The planter soon found that many suffering from some nervous or mental disorder could be taught a simple routine and thus could be profitably employed. No doubt by such methods the planter did help to rehabilitate many of his slaves. This is brought out in examining the probate court records. Quite frequently a slave listed as "unsound" would be appraised at almost his full value. Numerous such entries were listed in the James Hoover estate in Concordia Parish, La. The following slaves all listed as "un-

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sound" were valued as follows(5): Nancy, 23, \$600; Ann, 30, \$500; Louisa, 35, \$500; and Abram, 30, \$600. Other records list (6-8) as "not sound": Harriet, value \$700; Phillis, 55 years, \$400; and Jim, 44 years, \$400. Such values were probably not much below full market value.

In accounting for the discrepancies in the number of insane northern and southern Negroes in the 1840 census report, at least 2 factors may be pointed out. First, many of the figures were no doubt reported by the overseers, whose opinions as to whom to class as insane were very vague. For that reason many a Negro suffering from a nervous or mental disorder was not so reported. The other factor that influenced the planter in failing to report his "insane" Negroes was his method of profitably employing Negroes so afflicted. From an economic point of view these Negroes were earning their living and were therefore not to be considered "insane or idiotic." They were therefore not reported to the United States marshals charged with taking the census.

Further examination of the inventory and appraisal records of estates may serve another useful purpose in determining the mental health among slaves since the census report of 1840 was no doubt quite inaccurate. For this purpose the probate court records of several counties and parishes in Alabama, Georgia, Mississippi, and Louisiana were examined and all listings of nervous and mental diseases among slaves carefully noted.² A total of 31,170 slaves' records were checked, and of these 391 were listed as suffering from some nervous and mental disorders. These listings are grouped as in Table I with the exact descriptive wording of the affliction as given in the probate court records.

In order to determine the ratio of those suffering from a nervous or mental disease the neurologic listings (spinal injury, af-

² The following records were examined: Georgia, the county of Chatham; Alabama, the counties of Dallas and Montgomery; Mississippi, the counties of Adams, Franklin, Jefferson, Warren and Wilkinson; Louisiana, the parishes of Assumption, Caldwell, Catahoula, Claiborne, Concordia, East Carroll, East Feliciana, Franklin, Madison, Iberville, La-Fourche, Morehouse, Natchitoches, Ouachita, Plaquemines, Point Coupee, St. Charles, St. John the Baptist, Tensas, Terrebonne, West Baton Rouge, and West Feliciana.

TABLE I

Mentally deficient		Personality disturbances including mental illness		Epileptic and epileptic-like		Neurologic	
Idiot	58	Unsound	162	Epilepsy	1	Spinal injury	2
Simpleton and simple	6	Subject to spasms	2	Epileptic	10	Afflicted *	15
Defective	5	Fits of hysteria	1	Subject to fits	40	Paralysis	11
Imbecile	2	Insane	29	Falling fits	6	Paralyzed	1
Foolish	4	Crazy	24			Paralytic	3
		Deranged	2			Palsy and palsied	7
Totals	75		220		57		39
							391

* The term "afflicted" as referred to in the South usually means a physical abnormality.

flicted, paralyzed, paralytic, and palsy and palsied) were deleted. This gave a ratio of 1 to 85.8. Present-day estimates place the ratio of those suffering from mental illness and other personality disturbances at about 1 to every 16 people(9). The percentage distribution of these nervous and mental disorders was as follows: mentally deficient, 19.2%; personality disturbances including mental illness, 56.2%; epileptic and epileptic-like, 14.5%; and the neurologic, 9.9%. Table 2 compares the data on the ratio of the insane as reported in the Census Report of 1840 and the probate court records of slaves with the figures available today.

of every 85.8 slaves was suffering from some nervous or mental disorder. The figure for the entire population in the United States today is estimated at 1 to 16. Undoubtedly the slave record approaches more closely our present record than the figures actually show since such neurotic reactions as anxieties, phobias, obsessions, and others were not counted in the ante-bellum records although included in the estimates today. The inventory and appraisement records of that period therefore give a much more accurate picture of the status of mental health among the slave population than the census report for 1840.

TABLE 2

Population	Ratio of the insane	Source
Whites in North.....	1: 995	Census Report, 1840
Whites in South.....	1: 945.3	Census Report, 1840
Negroes in North.....	1: 144.5	Census Report, 1840
Negroes in South.....	1: 1,558	Census Report, 1840
Slaves (mentally deficient, personality disturbances, mentally ill, epileptic).....	1: 85.8	Inventory and appraisement records of estates as recorded in probate court records
Population today (mental illness and other personality disturbances)	1: 16	National Association for Mental Health

To summarize, an investigation was undertaken to determine the mental health of slaves on ante-bellum plantations, since it was quite evident that the first census report of 1840 was inaccurate. The inaccurate reporting of the "insane and idiots" among the southern Negro may have been due partly to the failure of the overseers to report such afflictions because of their poor concept as to whom to class as insane, and partly to the planters who because of their ability to teach their "insane" slaves some simple routine did not consider them as suffering such afflictions and did not so report them to the census takers. An examination of 31,170 slave inventory and appraisement records shows that 1 out

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FLUCTUATIONS OF TEMPORAL LOBE ELECTROENCEPHALOGRAPHIC ABNORMALITY DURING PSYCHIC FUNCTION

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It has to date not been possible to find in the electroencephalogram any close physiologic correlate of psychic function. In a recent extensive review of the literature(5) it was found that only 2 conclusions were justified. The first is that, in the presence of intellectual activity, alpha voltage and prevalence are diminished while, in the presence of intellectual relaxation or readiness, the alpha rhythm is active. Recent work by Magoun and his co-workers has demonstrated clearly that the process of becoming alert from a state of somnolence is accompanied by significant physiologic change. They were able to elaborate the anatomic and physiologic features of this alerting process. If one were to extend the concept of alerting from the transition from somnolence to the waking state, to the transition from relaxed wakefulness to the state of active intellectual functioning as, for example, in problem solving, then one might consider alerting in the waking human subject to be demonstrated by obliteration of alpha activity and relaxation by facilitation of alpha activity. The absence or depressed voltage of alpha activity in some anxious patients could then be interpreted as a state of continued intellectual alertness. In the review mentioned above, it was also concluded that affective experiences influence the electroencephalogram to the extent that they evoke or depress intellectual function. The second observation, made originally by Liberson, and confirmed by Kennedy and his co-workers, is that, during intellectual problem solving, brief runs of 6-10-per-second waves are seen in the anterior temporal regions in some subjects.

And yet the psychic life encompasses much more than problem-solving activity. The wealth of fantasies, thoughts, doubts, affects, and sensations seems to give no evidence of their appearance and disappearance and of the difference one from the other in the electroencephalogram. The observations of Hughlings Jackson that uncinate fits have psychic components, the observation of Da-

vidoff(1) that a psychic seizure might consist of a prolonged affective state with appropriate thoughts, and the observations of Penfield and his co-workers of the large variety of psychic components and equivalents of focal seizures derived especially from the temporal lobes—these constitute our principal clues to the relation between brain physiology and the psychic life. Thoughts, memories, dreams and fantasies, and feelings all appear as seizure elements or equivalents. Moreover, they could be reproduced on the operating table by Penfield by the process of electrical stimulation of the temporal lobes of patients subject to such seizures. All of this suggests that, in the electrophysiologic activity of the temporal lobe, one is likely to find some correlates with psychic activity if the proper technique of observation can be worked out. A second clue is Penfield's observation that psychic changes were elicited by the stimulation of only those temporal lobes that were diseased and had previously been the site of focal seizures. One possible inference is that, if the changes in the temporal lobe caused by disease are effective in facilitating a psychic response to surface stimulation, they might also be effective in facilitating the appearance on the surface of electrophysiologic changes more or less closely correlated with psychic changes.

In the present state of our ignorance concerning the site at which psychic functions occur and the type of coding by which memories are recorded, it is difficult to know *a priori* what type of psychic process would be easiest to recognize physiologically. Moreover, we know that it would be misleading to consider either a patient's spoken production, or indeed the entire content of his consciousness, if it were available to us, to be the only or the most important psychic process at any given moment. Psychoanalytic observations have made it clear that a large segment of psychic function occurs without the attribute of consciousness and that much that is important psychically cannot be brought to con-

sciousness by an act of will of the subject. The most reliable single indicator of the true psychic significance of any given thought, memory, fantasy, or image is the affective response to it. While the affective response can, as a result of certain psychic defensive procedures, at times be misleading, it is nevertheless fairly constantly true that those psychic stimuli or productions (images, memories, fantasies, thoughts) that evoke the same affective response have the same psychic significance to the individual. In any situation aside from an objective reasoning process—and such objective reasoning processes occupy only a very small fraction of the time during which psychic processes are active—affectively equivalent elements may substitute for each other. This type of substitution is seen in dreams, waking fantasies, distorted memories, wishes, hopes, and prejudices, in short, the things men live by. Therefore it would seem most promising, in any psychophysiological observation of temporal lobe activity, to attend especially to affective changes.

It is the purpose of this presentation to describe a single instance in which a correlation between psychic function and the electrophysiologic activity of the brain could be observed with the assistance of the clues just mentioned.

A 32-year-old man had been operated 10 years before this recent observation for removal of a meningioma of the right Gasserian ganglion. The operation was successful and the tumor removed. A year later, the patient returned with a left hemiparesis. Re-exploration disclosed extensive recurrence of the tumor. No further attempt at removal was made but x-ray therapy was administered and the hemiparesis cleared up completely over the next few months. The patient was left with trigeminal anaesthesia and masticatory weakness on the right. He was otherwise symptom-free until about a year ago when he returned to his surgeon with the following complaint. When standing momentarily unoccupied at the bar that he tended, the image of a penis would come to mind. There was no adequate provocation for this imagery. It was disturbing to the patient because he felt guilty about any conscious concern with sexual matters. Sometimes a memory from early childhood, usually the same memory, in which a school building appeared, would come to mind. The image of the penis, however, was by far the more frequent intruder and the more disturbing one. It might recur several times a day. It seldom occurred when the patient was occupied. He was so embarrassed that he did not discuss this with anyone. Careful psychiatric survey over a period of 2 hours during 2 separate visits failed to reveal

any other evidence of neuroticism. The patient had had no experience with obsessional thoughts or compulsive acts in the past. On the other hand, there was at no time any impairment of consciousness and certainly no convulsions. Neurological examination revealed only the disturbances of the fifth nerve noted above. Electroencephalographic examination revealed severe focal abnormality over the right anterior temporal region consisting of fast spikes as high as 150 microvolts in amplitude and slow waves at frequencies of 2-5 per second with a maximum amplitude of about 100 microvolts. All activity at the right anterior temporal electrode was continually abnormal although the frequency of the abnormal waves might vary from moment to moment.

Observation was made in the following manner. Electrodes were applied as usual and the electroencephalograph was operated in the usual way and at the usual tape speed (3 cm per second). The patient was seated in a comfortable chair and urged to say whatever came to his mind. I stood opposite him and occasionally intervened when I thought it was necessary to promote the flow of material. The door to our room was partly closed and outside the door in the adjacent room, operating the electroencephalograph, my secretary transcribed onto the electroencephalographic record all the patient's and my remarks in shorthand so as to indicate the time relation between the patient's words and his electroencephalographic activity while he was saying the words. After the observation was completed, the shorthand notes were transcribed into longhand on the same record. There were of course some omissions and some errors owing to poor acoustical arrangement. Observation and recording were continuous over a 50-minute period. From the record, I was able to select several selections representative of each of 4 types of affective experience: (1) pleasant reminiscences, (2) obsessive thoughts, (3) an attempt to abolish obsessive thoughts usually associated with embarrassment or self-consciousness, (4) the feeling that "my mind is a blank" or its equivalent.

Three representative samples are presented. The first channel is derived from the right frontal and right anterior temporal electrodes. The second channel is derived from a symmetrical lead on the left. The third channel is derived from the right and left mid-temporal electrodes and the fourth channel is derived from the right and left occipital elec-

trodes. The patient's words are written between the third and fourth channels and my words are written between the first and second. The strips in each figure are continuous.

Fig. 1 illustrates pleasant reminiscences. The sample was recorded a few seconds after the patient asked me a question that I did not answer. He is saying, "Things I used to ask Dr. C and he wouldn't answer me, I thought he was pretty smart. Always admire intelligence. When he said something, I asked

Fig. 2 demonstrates the nature of the electroencephalographic activity when the patient attempts to handle his obsessions by suppressing them. He is saying, "All the while the thought breaks in, this is not interesting to anybody. Nothing special is in my mind. All these things pop in and pop out." As the patient says "all these things" (meaning obsessional contemplation of a penis) spikes and 2-3-per-second moderate voltage waves appear. After he says "pop in and

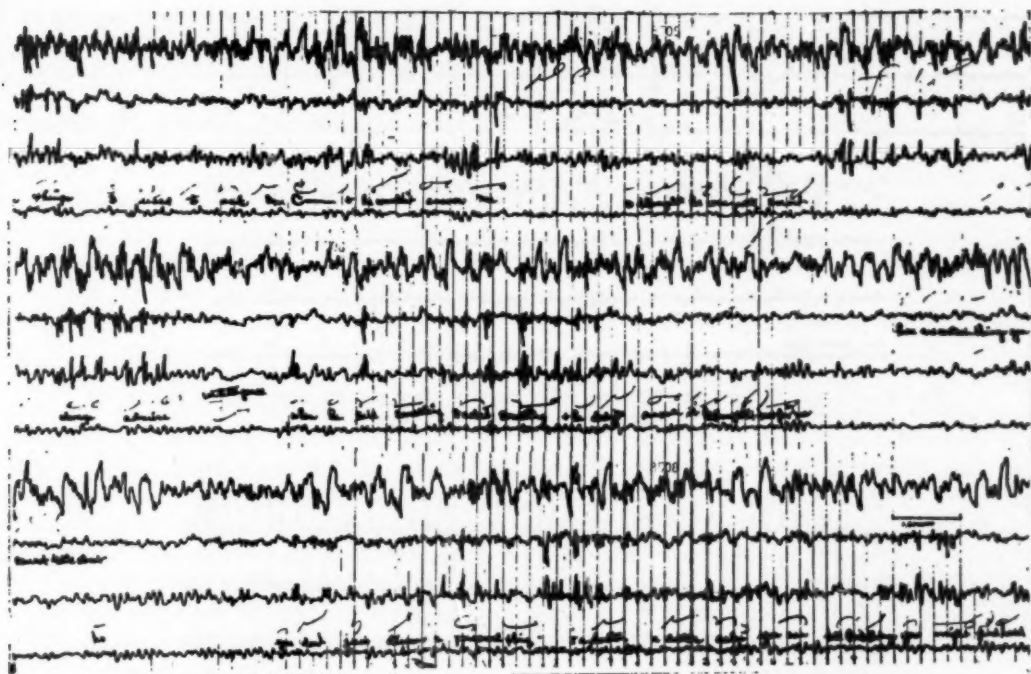


FIG. 1.—Sample of EEG recording during pleasant reminiscences.

something and he didn't answer it, he thought it best for me." I replied, "There are certain things you cannot talk about." He said, "No, you just don't discuss a personal thing with a doctor. A doctor asks, you can tell him things you might find hard." Notice that as the patient talks about his doctor admiringly the record shows continuous, slow, high voltage activity with high voltage, fast spikes. This specific detailed pattern of spike and double wave seen as he says, "I thought he was pretty smart" is very similar to the pattern appearing at another point as the patient said, "How beautiful he played his part."

pop out" there is fairly regular run of 5-6-per-second activity lasting about 3 seconds and terminated when the patient resumes his remarks "it doesn't seem important to me. As we talk of these things it just pops in and then doesn't stay." When the patient says "as we talk of these things" a spike and some slow activity appears and immediately following the remark "then doesn't stay" there is a suppression of all activity followed by the regular 5-6-per-second activity seen previously.

Fig. 3 illustrates the type of record obtained on each of the 4 occasions when the patient said, "My mind is a blank." Psycho-

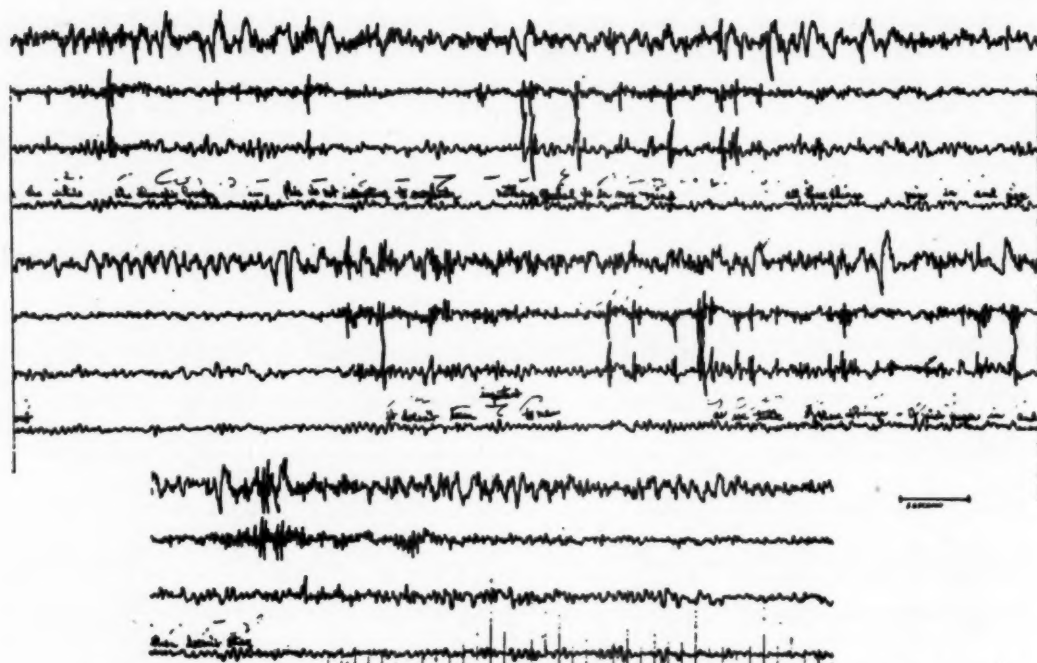


FIG. 2.—Nature of electroencephalographic activity when patient attempted to handle his obsessions by suppressing them.

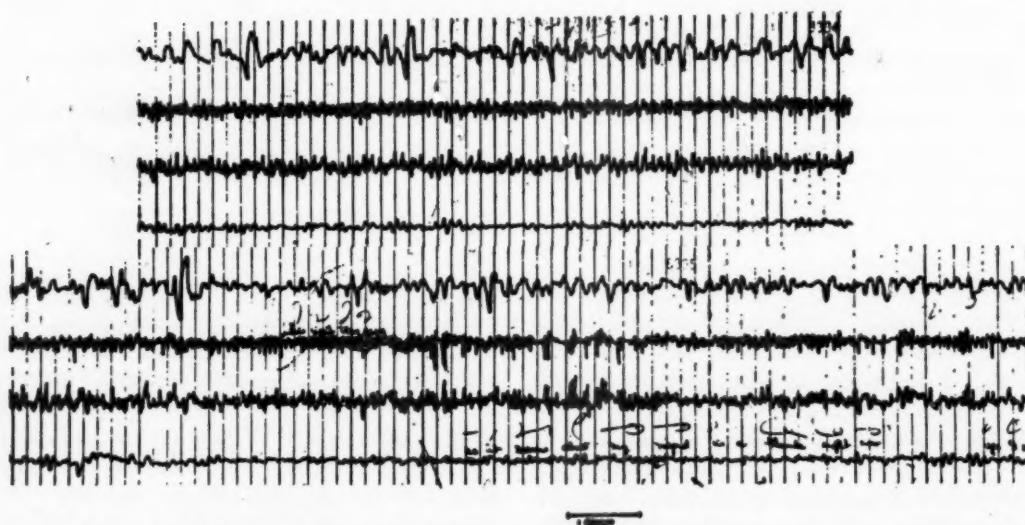


FIG. 3.—Type of record obtained on each of 4 occasions when patient said, "My mind is a blank."

analytic experience teaches us that this response to the demand to associate freely usually means that the patient is trying to suppress unwelcome thoughts. As the patient is silent, slow activity of moderate to high voltage and some spikes are seen. These are interrupted when I remark, "This isn't very easy," and there is no return of the slow activity as the patient replies, "No, it seems about my mind is a blank right now."

All the data available in the record may be summarized as follows. As the patient indulges in pleasant reminiscences moderate to high voltage 2-3-per-second activity with high voltage spikes are seen at the right anterior temporal electrode. When thoughts that do not carry this pleasant affect or when unwelcome obsessive thoughts occur to the patient, they are accompanied by low to moderate voltage 2-3-per-second activity with lower voltage spikes. As the patient describes his rejection of an unwelcome idea, the slow activity and the spikes are replaced by relatively low voltage 5-6-per-second or 12-15-per-second activity. Similarly when the patient says, "my mind is a blank" (from which we may infer an attempt to suppress unwelcome thoughts) the relatively fast rather than the relatively slow activity is seen. Occipital alpha activity could not be related to the patient's productions in this way. Mental computation influenced neither the abnormal anterior temporal activity nor the occipital alpha.

One may comment briefly on the reliability of these findings. The fact that the conversation was recorded by a secretary rather than automatically throws some question upon the precision of the timing. It is also true that any delay that occurs need not necessarily be constant. However, I do not think that need constitute a serious objection to accepting these findings since a lack of precision in timing could only obscure and certainly not simulate a true relation. In other words this source of difficulty could give only false negative and not false positive results. However, to make the method more precise, in subsequent work a sound track is being recorded in one of the channels of the electroencephalograph with ample cues to provide split-second timing. The actual conversation is simultaneously recorded on a wire recorder. Preliminary observations with this device are confirmatory.

While it seems to me that the fluctuations in the type and amount of abnormality in this case are fairly clear-cut in their moment-to-moment variation, I am sure that similar relations could be detected in other cases, which might show finer changes if more precise automatic methods of correlation were available. There are such automatic correlating devices and their use would probably provide a great deal more information than is available by this relatively crude method of visual inspection. However, the material in this case demonstrates that, even without such refinements, significant experimental observations of this kind can be made.

Of course one wonders to what extent one may be dealing with the simple activation effect mentioned in the first paragraph of this paper. When the electroencephalogram was recorded with the patient sitting quietly with his eyes closed and not reporting, there was a prominent, fairly constant, regular alpha activity at 100-150 microvolts. The 2-3-per-second high voltage anterior temporal abnormality, with spikes, is also fairly active but is not nearly as consistent as the alpha activity nor are the variations in these 2 forms of activity related to each other. During the entire experimental period, the patient seemed to maintain a fairly constant state of alertness, probably in an attempt to please the examiner by producing adequate material. The alpha voltage and percent time were fairly constant, the former remaining between 50 and 100 microvolts. There were no really clear-cut fluctuations in amount of alpha activity and certainly none that could be related in any way to the patient's verbal productions or to the temporal abnormality. Calculation produced no effect on either occipital alpha or temporal slow activity. I suspect that there were variations in the degree of "alertness" in the following sense. During expression of thoughts that were not embarrassing to the patient, one might expect a decreased intrapsychic vigilance, while the attempt to suppress embarrassing or unpleasant thoughts might provoke increased intrapsychic vigilance or alertness. Possibly finer correlating techniques might have been able to demonstrate some significant correlation between this attentiveness and the occipital alpha activity; however, we should first have

to have a fairly sensitive, reliable, objective measure of "attentiveness." Moreover it seems to me that this relatively sensitive connection between positive and negative affects and electroencephalographic abnormality in the anterior temporal region is much further "upstream" in the psychophysiologic process than the relation between attentiveness and occipital alpha.

I believe that one may conclude from this demonstration that, by taking advantage of a certain kind of temporal lobe disturbance, one may demonstrate a moment-to-moment correlation between the affective significance of the patient's thoughts and the electroencephalographic activity of a focal area of abnormality. One may imagine the mechanism in the following way: a large group of cells that ordinarily beat asynchronously is caused by the lesion to beat synchronously and thus amplify and bring to the surface a relatively low voltage activity ordinarily found only within the depths of the temporal lobe. If one assumes that high voltage spikes and waves signify that the structure whose function we are recording is not available for the performance of its normal function and that lower voltage relatively faster activity signifies that the structure is relatively more available for normal functioning, then one may infer that in this case the conscious appearance of pleasant thoughts is associated with relative inactivity of that portion of the temporal lobe whose activity we

are recording, and the attempt to suppress (or repress?) unwelcome thoughts is associated with relative activity of the same region.

Finally, these observations provide a clue to the mechanism whereby affective changes may precipitate seizures in patients with temporal lobe disease.

SUMMARY

By taking advantage of a disturbance of the temporal lobe it has been shown that, in one subject at least, there is a moment-to-moment correlation between the affective significance of thoughts and electroencephalographic activity.

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PSYCHOLOGICAL IMPLICATIONS OF THE "ACTIVATING SYSTEM"¹

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In his posthumously published *Outline of Psychoanalysis* Freud(3) repeated the hope that some day methods of therapy would be developed that would surpass that of psychoanalysis, that "the future may teach us how to exercise a direct influence, by means of particular chemical substances, upon the amounts of energy and their distribution in the apparatus of the mind" (p. 79). Admitting that we are far from such a goal, implicit in Freud's hope is the need to seek correlations of new advances in neurophysiology with clinical psychiatry and psychoanalysis. Hypotheses must be formulated if new data are to be utilized for further investigation. The following material is presented with this view in mind.

In recent years Magoun and his co-workers(11) have focused their researches on the "activating system" of the brain stem. The basic phenomena involved can be outlined roughly as follows: If spontaneous electrical activity is recorded from the cerebral hemispheres of a normal animal as it passes from wakefulness to sleep, low voltage fast discharge associated with alert wakefulness is seen to give way to large slow waves and spindle bursts during sleep. The alteration is reversed as the animal awakens. If the sleeping animal is awakened suddenly, as by a handclap, an activation pattern of low voltage fast discharge appears abruptly with behavioral alertness. This alteration is called the "electrocortical arousal reaction," and it provides an objective record of the role of afferent stimulation in evoking the waking state. The arousal reaction persists well beyond the duration of the arousing stimulus itself.

These investigators found that direct electrical stimulation of a portion of the brain stem was capable of reproducing the electrocortical events encountered in awakening from sleep or in the electrocortical arousal reaction. The region whose stimulation accomplished this was distributed through most of the length of the brain stem as a central core

of tissue. Within this region 2 functional systems could be distinguished. The first could be identified as the laterally placed ascending somatic and auditory pathways, the direct stimulation of which as far forward as the midbrain sets up the arousing influence of peripheral excitation. The second system, situated medially to the ascending sensory pathways, yielded arousal effects on stimulation that were even more striking. This second system did not correspond in distribution to known anatomical paths and appeared to be made up of a series of ascending relays coursing forward from the reticular formation of the lower brain stem through the mesencephalic tegmentum, subthalamus, hypothalamus, and ventro-medial thalamus to the internal capsule.

Now we come to the truly remarkable part of their findings. If all the sensory pathways are interrupted at the midbrain level, the animal remains as wakeful as a normal animal, and its electrocortigram exhibits typical activation. In contrast, interruption of the ascending reticular activating system at the same level with the sensory pathways remaining intact leaves the animal as though deeply asleep or anesthetized. Its electrocortigram exhibits the large slow waves and spindle bursts of sleep. The former preparation, that is the wakeful animal, is able to sleep as well. When such an animal is asleep, both auditory and somatic stimulation are still capable of awakening the animal behaviorally and activating its electrocortigram. Obviously this can only occur by the ascending transmission of an activating influence through the medial reticular formation that is left, since the sensory paths themselves have been interrupted. Here is the crux of the matter: This arousal from sleep by excitatory stimuli *that the animal presumably cannot hear or feel* suggests that afferent stimuli induce or contribute to wakefulness not by the direct arrival of sensory discharges at the cortex, but indirectly, and at a subcortical level, by excitation of the ascending reticular activating system within the brain stem.

This work of Magoun and associates re-

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minds us of the fact that sensory stimulation serves a twofold function. It brings information from the environment, thus providing specific data concerning reality. However, it also has the additional function of arousing and alerting the organism, making it more aware of stimuli in general. The work indicates the mechanism whereby the latter function is mediated. That this activating system exerts an *over-all* effect on consciousness is indicated by the fact that the same system when activated exerts pronounced facilitory influences on lower motor outflows, so that it apparently functions normally both in descending and ascending directions to subserve, on the one hand, behavioral facilitation and, on the other hand, the central alertness that characterizes the waking state.

The work of Jasper and associates (6), too, is pertinent to the thesis I wish to propound. Whereas the system investigated by Magoun and his co-workers exerts its effect upon the cortex in a generalized manner without evidence of topographical localization, there exists in the thalamus a corresponding system, topographically organized to exert a similar activating influence upon more restricted areas of the cortex. Furthermore, Jasper and his co-workers were able to demonstrate that, in addition to the previously described influence of the brain stem activating system on the cortex, a converse phenomenon exists, namely that stimulation of specific areas of the cerebral cortex can modify the activity within the reticular system of the brain stem. Thus, the latter is placed under the control of sensory stimuli from without and cerebral cortical elaboration from within.

It is well to recall at this point that not all sensory stimuli are equally capable of arousing or activating the organism and that the *meaning* of the stimulus is ultimately the matter of chief importance. One need only think of the mother who can sleep soundly while elevated trains roar past her window but is awakened by the first soft cry of her baby. The corticofugal system provides the mechanism whereby this sort of function may be mediated.

Leaving now the firm ground of neurophysiological research one may be permitted a theoretical flight and consider some possible psychological implications. One can picture

the process of perception as taking place in the form of a feedback. Consider the following hypothetical sequence of events: (1) The perception of an experience enters the brain stem as a complex of sensory impulses. (2) These impulses are carried over collaterals into the ascending reticular activating system (to be referred to as the A. R. S.). (3) Stimulation of the A. R. S. is followed by arousal or alerting of the cortex. (4) The alerted cortex scans the sensory impulses coming in directly as to their meaning. (5) The cortex then fires impulses back to the A. R. S., the nature of which depends on the meaning of the perception. For example, if the perception is one of personal concern, then the A. R. S. will be activated further and the perceptions that arrive in the cortex will be subjected to still more intense scrutiny. If the perception continues to be of interest, activation of the A. R. S. may take place still further, and continue in steplike increases until the perception in question occupies the full attention of the individual to the exclusion of everything else. On the other hand, a lesser degree of activation may take place, permitting attention to be shared with other percepts. Or, the perception may have been without meaning to the individual, in which case no corticofugal activation of the A. R. S. takes place and the perception consumes only a minimal quantum of attention.

One can carry this analysis a step further and consider the case where the perception arouses anxiety, not some fear to which the alerted individual can respond with appropriate corrective behavior, but some unescapable fear, having its origin either in a potentially overwhelming environmental situation or internally from some psychopathological state. In that case we might picture a flow of corticofugal impulses, the function of which is to "deactivate" the A. R. S. Such a corticofugal stream could function as a barrier against stimuli of unbearable emotional intensity (Reizschutz(4)). If the total environment were threatening in catastrophic proportions, the resulting "deactivation" of the A. R. S. might be so complete that consciousness is lost. Thus, an individual may faint in the face of some unbearable psychological situation. Lesser degrees of deactivation in such a situation might result not in

outright fainting but in a clouded state of consciousness in which the experienced anguish is considerably mitigated. In disaster areas, for example, one sees at times, as an immediate reaction, a dazed mental state during which the victims seem to be under the influence of a marked inhibitory force with panic strikingly absent (5). It is not until this immediate reaction, which lasts only a few minutes, subsides that uncontrolled panic makes its appearance. If the source of the anxiety involves not the entire environment but some circumscribed aspect of it, then corticofugal impulses might result in deactivation at a thalamic level where circumscribed deactivation could take place. The result would be an alteration limited to the specifically traumatic perception and a diminution in the capacity of the latter to produce cortical arousal.

It appears that the direct cortical informational aspect of stimuli relates to the intellectual aspect perception whereas the indirect arousal-exerting effect is related to the emotional aspect. If corticofugal impulses exert a sustained "deactivating" effect on the brain stem A. R. S., it could conceivably express itself on a psychological level as feelings of depersonalization or derealization. On a thalamic level (with its more circumscribed effects) it could express itself on a psychological level as denial, repression, and isolation (8).

Neurophysiologic events in sleep and dreams may be similarly formulated. Let us assume that fatigue, whatever its nature, acts on the A. R. S. by decreasing its sensitivity to stimuli. This lessened sensitivity deepens as sleep sets in. More and more stimuli become incapable of arousing the cortex. If the stimulus is sufficiently strong it can produce complete cortical arousal in spite of fatigue. However, quantity is not the sole factor. In the example of the sleeping mother it was indicated that even in sleep the meaning of the stimulus plays a role. We may assume that what takes place in sleep is similar to the feedback mechanism previously described, with one important exception. Incoming perceptions are all scrutinized on a cortical level from one point of view, namely, "Is this stimulus important enough to demand my waking up?" If the answer is negative then

no increase in the reactivity of the A. R. S. takes place. The perception may be extinguished completely and sleep still continue undisturbed. Or, a dream may occur. In this case, the state of partial cortical arousal permits certain distortions in the perception to take place. As a result the sleep-disturbing stimulus becomes transformed into a carrier of various wish fulfillments that make continued sleep desirable (8, 9). If, on the other hand, cortical scrutiny of the incoming perception signals danger, the sensitivity of the A. R. S. is increased. Stimuli now cause an intensified cortical arousal reaction and the subject awakens.

According to this conception, depth of sleep is a function of the state of reactivity of the A. R. S. At the end of a night's sleep, when the effects of fatigue have worn off, sensitivity of the A. R. S. rises. Stimuli become increasingly capable of effecting cortical arousal. As a result dreams and complete awakening are more apt to occur at this time.

If we suppose that sedative agents act, in part at least, on the A. R. S. by diminishing its reactivity, the consequence would be that the arousal effect of stimuli in general would be lessened. This is, of course, the effect one seeks on administering sedatives, to retain as much of conscious awareness as is compatible with the elimination of disagreeably excessive arousal reactions.

Following electroconvulsive therapy (ECT) patients show in their EEG slow wave activity like that seen in animals after destructive lesions of the A. R. S. (7). One wonders whether the therapeutic effect may not depend on an ECT-induced diminution in the reactivity of the A. R. S. as a result of which previously traumatic experiences are no longer capable of eliciting disagreeably excessive arousal reactions. The drugs or ECT need not act directly on the A. R. S. They might do so indirectly via corticofugal fibers. This is most likely where psychosurgical procedures exert their effects. If the cortex has been firing an excessive stream of "deactivating" impulses at the A. R. S. then interruption of corticofugal impulses makes possible a variety of release phenomena. With such a complicated interplay of forces it becomes understandable why it is not always possible to predict the new line of defense that the in-

dividual will take up when this system has been tampered with. One may be permitted to wonder, too, whether a direct attack upon the A. R. S. by means of the stereotaxic apparatus used by Spiegel and his co-workers (12) might not open a new investigative field in psychosurgery.²

It is a commonplace observation that the reduction of sensory impressions is routinely cultivated in seeking sleep. Fewer sensory impressions mean fewer impulses into the A. R. S. that arouse and alert the organism. However, it is equally well known that sleep does not follow inevitably on the elimination of impressions from without. It may be the result of the fact that the A. R. S. is fired not only by collaterals from without but by corticofugal impulses from within. When the latter decreases, as a result either of fatigue or organic brain damage, the individual becomes increasingly dependent on external stimuli in order to maintain full conscious awareness. Such individuals, when shut off from external stimuli, tend to drift off into lower levels of consciousness.

In a recent study of patients with senile cataracts (10) it could be shown that the cataract was part of a senile degenerative process that was affecting the brain diffusely. Many of these patients expressed a subjective awareness of diminished capacity for immediate recall. In line with the foregoing hypothetical formulation one may suppose that the impairment in recent memory was the result of a diminution in the number of activating corticofugal impulses to the A. R. S. During the postoperative period, when both eyes were bandaged, many patients became disoriented, delusional, and hallucinated. A reassuring word from a nurse was often sufficient to bring a psychotic episode to an end. The patient was often startled by this intervention and would speak of having been "awakened

from a dream." He was indeed awakened, not from a dream but from a psychotic episode. The stimulus provided by the nurse alerted the cortex of the patient via the A. R. S. and increased his awareness of stimuli in general.

At times it was possible in these cataract patients to observe 2 ego states functioning side by side, one denying reality in a variety of delusional and hallucinatory wish-fulfillments, the other more accurately in contact with the environment. At such times the patient would behave like a dreamer in the midst of a nightmare, who reassures himself that he is quite safely asleep and can rescue himself any time he chooses by waking himself up. By judicious interventions one could permit the patient to drift off into a psychotic state or "come back again." When the eyes were unbandaged and a new channel of perception was opened to the patient these episodes occurred much less frequently and then primarily at night when alerting external stimuli were diminished.

The phenomenon of double simultaneous stimulation has been studied extensively by Bender and his co-workers (1). One outgrowth of their work is what they have called the "Face-Hand Test" (2). If the cheek and hand of a subject are simultaneously touched when both his eyes are closed, many normal persons will report that they felt only the touch on the cheek. If the subject is now alerted to the possibility that he will be touched in more than one place and the procedure is repeated, most normal people will detect both touches thereafter. One may advance the view that by alerting the subject to the possibility of more than one touch his A. R. S. is fired by the warning via corticofugal fibers. The stimulated A. R. S. now activates the cortex, thereby increasing the level of consciousness and the awareness of stimuli in general. In this setting of heightened awareness the subject becomes capable of perceiving both stimuli. If on the other hand the individual is suffering from some organic process that affects the A. R. S. directly or indirectly via corticofugal fibers, further activation cannot take place. In spite of the pretest warning by the examiner the subject responds to the 2 stimuli with insufficient activation and is not capable of expanding his

² Recent observations by Scoville *et al.* (A.R.N.-M.D., Vol. 31, "Psychiatric Treatment," Chapter 30, p. 367) are strongly suggestive in this regard. In an extensive series of operations on the temporal lobes of psychotic patients they accidentally produced in 2 patients severe injuries to deep midline structures in the brain stem. The most profound behavioral alterations with complete remission of the psychoses in their series occurred in those 2 cases. They were able to add from the experience of colleagues 2 more patients who also showed this astonishing result.

horizon of awareness sufficiently to encompass the 2 separate stimuli. Subjects with considerable anxiety often behave like "organic" patients on the face-hand test(1). In them, the narrowed horizon of awareness that this indicates is the result, theoretically, of corticofugal deactivating impulses. Such functional deactivation would serve defensively, as a barrier against further stimuli, protecting the already traumatized organism from further stimulation(4).

SUMMARY

Recent advances in neurophysiology relating to the so-called "activating system" have been summarized. Tentative correlations have been suggested concerning the properties of this system and certain psychological phenomena associated, primarily, with the mechanisms of defense.

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OFFICIAL REPORTS

THE LOS ANGELES MEETING

The 109th Annual Meeting of The American Psychiatric Association was held at the Statler Hotel in Los Angeles, California, from May 4 to 8, 1953.

The official registration figure was 2,808, of which 1,260 were members (508 of the 1,548 nonmembers were women).

This was the third year of the mail ballot. Dr. Crawford Baganz, Chairman of the Board of Tellers, reported the gentlemen elected from candidates presented by the Nominating Committee and by petition.¹

On Monday morning a very thought-provoking and stimulating address on "Psychiatry and Citizenship" was delivered by Dr. D. Ewen Cameron, the retiring President.

Monday evening was devoted to a special program sponsored by the Committee on International Relations. The meeting was addressed by Dr. D. Ewen Cameron, Dr. Winfred Overholser, Dr. Jose Angel Bustamante, and Dr. G. Ronald Hargreaves, a Corresponding Fellow from Switzerland. The annual academic lecture was given on Wednesday morning by Dr. Sandor Rado, of New York, on "Dynamics and Classification of Disordered Behavior." An interesting discussion by Dr. Karl A. Menninger, Dr. Francis J. Gerty, and Dr. George N. Raines followed.

For several years it has been the custom to hold a luncheon on Tuesday for all Fellows of the Association, at which time the Certificates were presented to new Fellows. This year none but new Fellows were invited to this luncheon, and their Certificates will be delivered to them by mail.

For the second year a precedent was broken by having no formal address at the annual dinner on Wednesday evening. This was a very enjoyable affair, and was attended by 521 members and guests. The President, retiring officers, Councillors, and Committee Chairmen were presented with a Certificate

of Commendation. The Mental Hospital Service Awards were presented as follows: First Award to Selkirk Mental Hospital, Manitoba (Edward Johnson, Supt.) for pioneering volunteer programs in Canadian hospitals; Second Award to Enid State School, Oklahoma (Mrs. Anna Scruggs, Supt.) for actively assisting in raising bond issue for new building resulting in full-time education, medical, and recreation program for all children; Third Award to V. A. Hospital, Sheridan, Wyoming (E. S. Post, Mgr.) for developing therapeutic optimism throughout hospital by good administrative and educational practices; Honorable Mention to Polk State School, Pennsylvania (Gale H. Walker, Supt.) for establishing effective TB treatment and control program; Honorable Mention to Anna State Hospital, Illinois (R. C. Steck, Supt.) for introduction of mental health education program; Honorable Mention to Sonoma State Home, Eldridge, California (Charles Ludwig, Clinical Director) for establishing preadmission diagnostic service that has cut down the waiting list for urgent cases.

The Lester N. Hofheimer Prize for research went to Thomas H. Holmes and his co-research workers Helen Goodell, Stewart Wolf, and Harold G. Wolff for their work on "The Nose." The Isaac Ray Award was presented to Dr. Gregory Zilboorg. A delightful entertainment followed the dinner, which was, in turn, followed by dancing.

Mrs. Glenn Myers acted as Chairman of the Ladies Committee on Arrangements. Her committee provided delightful entertainment for the visiting ladies, and gave a particularly attractive luncheon in honor of Mrs. D. Ewen Cameron, wife of the President of the Association, which was followed by what we are told was a most interesting and eye-filling fashion show.

Friday morning at the business session for members, Dr. D. Ewen Cameron, retiring President, gave the gavel to Dr. Kenneth E.

¹ See report of Board of Tellers on page 73.

Appel, at which time he assumed the Presidency of the Association. At this meeting the Past President's Medal was presented to the retiring President, by Dr. Winfred Overholser. The new Council elected as members of the Executive Committee Dr. Francis J. Gerty and Dr. Walter E. Barton.

Among the important actions of Council that were approved by the members during the several business sessions, the following are of especial interest:

It was decided to hold the next Annual Meeting in St. Louis, Missouri, from May 3 to 7, inclusive, 1954.

The District Branches of the Bronx, Nassau, New York County, and South Central (Louisiana-Mississippi), which had previously been voted on by Council, were approved by the membership. The following District Branches, which had previously been approved by the Executive Committee, and later favorably voted on at the May, 1953, Council meeting, were approved as submitted to the membership: Central California District Branch, Southern California District Branch, Colorado District Branch, and Quebec District Branch. The following District Branches, their new and revised applications having been passed by Council in May, 1953, were voted on favorably by the membership: The Virginia District Branch, and the North Pacific (Oregon-Washington-British Columbia-Alaska) District Branch were approved. The President announced, after these branches had been accepted, that there were now a total of 16 District Branches, which was twice the required number, and the Assembly of the District Branches of The American Psychiatric Association was automatically established. Council received the advice of the Assembly concerning the regulations governing District Branches and Affiliate Societies and these were acted on favorably by the membership:

(a) Each and any APA member, having proper geographic qualifications, should, on his application, be accepted as a member of the District Branch in his area; or, if, in the opinion of the District Branch, he is not acceptable, such information as is pertaining to his status be referred to the Council for appropriate action. No APA member should be compelled to become a member of a District Branch. (b) A general policy of recog-

nizing that the term "residence," where it has reference to the making of an application for the establishment of a District Branch, shall be construed as meaning the place of work of the member making such reference. (c) District Branches may not overlap with respect to the area from which they derive their membership. (d) District Branches and Affiliate Societies may overlap with respect to the area from which they draw their membership. (e) The creation of new District Branches should be a matter of joint APA and local planning, to ensure ultimate total coverage of the area served by the APA. (f) Council may from time to time, either on its own initiative or at the request of the Assembly, or of a District Branch, or of the membership in session at the Annual Meeting, review the areas from which existing District Branches draw their membership, and make recommendations to the APA at an Annual Meeting.

Other actions of Council: Accepted the Finger Lakes Neuropsychiatric Society of New York as an Affiliate Society. Adopted a policy to the effect that dues will not be remitted for the year in which a registration is submitted. Determined to make every effort to increase the number of Corresponding Fellows, and decided to continue the policy of making no charge for dues for the Journal and for other publications. Decided that all topics submitted to the District Branches for discussion and opinion will be determined by the Council. Announced that the Association had been properly certified by the Treasury Department of the United States Government to enable the APA to receive gifts for the endowment fund tax-free. Set up an Ad Hoc Committee to consider the policies required to control the arrangement for the membership list. Appointed Dr. Jacques S. Gottlieb as APA representative on the National Research Council. Adopted a report of the Committee on Clinical Psychology with respect to the nature of psychotherapy and the necessity for medical training, diagnosis, and psychotherapy as a treatment and in administering this treatment. Council further instructed the Committee to attempt to reach an agreement to clarify the relationship of psychology and psychiatry, and authorized the Committee on Clinical Psychology and the Committee on Legal Aspects of Psychiatry to consult

with the American Medical Association Committee on Mental Health, and take steps toward the setting up of a model certification bill for clinical psychologists. Decided to discuss with the various states steps toward desirable changes in the Medical Practice Acts of the states. Directed a protest to the Veterans Administration in regard to the budget curtailment for consultant and attending services in VA hospitals. Appointed an Ad Hoc Committee to study the desirability of setting up divisional meetings of the APA since a large number of the members cannot attend Annual Meetings. Communications will be opened with District Branches and Affiliate Societies in the western part of the country for a divisional meeting in that area in 1955. Continued study was made of the question of malpractice insurance, as well as group health and accident insurance for Members of the Association. Installed an office of information in the Medical Director's office. Denied the right of Fellows or Members to revert to Associate Membership. In event that a Fellow or Member resigns and reapplies, he should not be considered for a class of membership below that from which he resigned. The dues of an Associate Member shall be the same as for a full member after having been an Associate Member for 5 years. Changed the title of "Corresponding Member" to "Corresponding Fellow." Elected to the Hofheimer Prize Board, Dr. Karl M. Bowman and Dr. Jerome D. Frank. Chose Dr. Henry W. Brosin as representative of the American Board of Psychiatry and Neurology. Recommended that legal counsel be employed for Association business. Moved strong liaison in scientific matters between the APA and the Academy of General Practice. Changed the name of the Ad Hoc Committee on the Consolidation of APA offices to the Ad Hoc Committee on "Permanent Home" for the APA, and urged Committee to bring in immediate plans for the raising of funds for such a home to be located wherever, in the opinion of the Committee, it would best serve the interests of the Association. Voted to appoint a committee whose twofold function would be to meet with the Mental Health Committee of the AMA, and study our total relationship with all the committees and divisions of the AMA that are related to men-

tal health. Authorized the planning of a conference of national psychiatric mental health organizations under the joint sponsorship of the APA and the AMA. Recommended the appointment of an Ad Hoc Committee on the Economic Aspects of Psychiatric Practice. Adopted the recommendations of the Joint Commission on Accreditation of Hospitals: (1) that the APA survey and rate psychiatric hospitals, both public and private, in the U. S. A. and Canada, (2) that this Commission issue certificates to fully accredited psychiatric hospitals, and (3) that the APA, in surveying psychiatric hospitals, accept the standards of the Joint Commission on Accreditation of Hospitals in rating other departments than those of psychiatry in psychiatric hospitals, and in surveying general hospitals with psychiatric departments, that we accept and use the standards of The American Psychiatric Association.

The Long-Term Planning Commission recommended a policy as to the proper budgeting of the Association's funds; the functioning of committees; the means of communication; problem of APA relations with other associations; problems incident to the growth in membership; problems regarding Corresponding Members; and other problems of organization and procedure in handling the affairs of the Association.

It was announced that the Assembly of the District Branches had been established, and its first report to Council was accepted. The Assembly was requested that the designation of the presiding officer be that of "speaker" rather than "president." Changed the name of the "Committee on Leisure Time Activities" to "Committee on Cooperation with Leisure Time Agencies."²

The Committee on Arrangements under the Chairmanship of Dr. Cullen Irish did an excellent job, and everything was done without apparent effort and without confusion. The technical details, hotel arrangements, eating places and similar facilities were arranged most successfully as usual by the Executive Assistant, Mr. Austin M. Davies, and the Association expressed its gratitude in resolutions to Mr. Davies, the Committee on Ar-

² Other actions taken by Council will be reported in the complete Proceedings in a later issue of the JOURNAL.

rangements, the Ladies Committee of Entertainment, Dr. David A. Young and his committee for a very excellent program. Comment should be made on the excellent publicity and fair newspaper coverage, which was due to the very proficient planning of Mr.

Robert Robinson of the Medical Director's Office. Thanks were extended to Mr. Jack Meacham, Managing Director of the Hotel Statler, and his associates and to all the employees of the Hotel Statler.

R. FINLEY GAYLE, JR., M. D.

SPECIAL NOTICE

REPORT FROM NOMINATING COMMITTEE

Dr. Henry Brosin, chairman of the nominating committee for 1953-54, solicits letters from the membership proposing nominees to the various elective offices of The American Psychiatric Association. It is expected that the nominating committee will meet in New York at the end of October to bring in its recommendations. Letters proposing names for nominations should therefore reach the committee not later than October 15, if possible. They may be addressed to any member of the nominating committee, which was appointed by Dr. Kenneth E. Appel and includes the following: Dr. Henry W. Brosin, Pittsburgh; Dr. Leo H. Bartemeier, Detroit; Dr. Frank H. Luton, Nashville, Tenn.; Dr. Walter Rapaport, Agnew, Calif.; and Dr. James H. Wall, White Plains, N. Y.

COMMENT

PSYCHIATRY: A MEDICAL SPECIALTY AND/OR—WHAT?

A review of contemporary medical literature, both monographic and periodical, yields this impressive observation: While surgeons, internists, ophthalmologists, and other specialists present essentially the results of clinical experience and research, psychiatrists—all of us—expend, in addition, much oratory and paper in talking and writing about “psychiatry.” We are still groping for a formulation of the scope of our professional interests. It is not difficult to understand this preoccupation. Alert practitioners of any branch of medicine do not restrict themselves exclusively to bedside, office, and laboratory. National and global problems of sanitation, epidemiology, food and drug supply, and adequately distributed availability of medical care are real, acute, and quotidian. Physicians have accepted the responsibility for public health, over and above the traditional concern for the individual patient. This has resulted in concrete, practical, effective measures that have tended to increase longevity, reduce infant mortality, and prevent or attenuate diseases once dreaded as uncontrollable scourges.

Psychiatry has unquestionably a legitimate place in such a scheme. We can point with justifiable pride to a number of major accomplishments. We have lessened the formerly fatal aspect of general paresis. We have exploded the notion of the inevitable hopelessness of all schizophrenias. We have improved substantially the lot of hospitalized psychotic people. We have, under the current heading of psychosomatic medicine, brought to our colleagues an appreciation of personal and interpersonal issues, beyond the concentration on physical illness as a seemingly isolated event. We have acquired an unprecedented skill in “understanding” and treating neurotics. We have declared—and, I believe, proved—our readiness to alleviate the everyday problems of the everyday person who comes to us for help. We have put our knowledge at the disposal of education, jurisprudence, and personnel management.

But this is a far cry from flaunting “psychiatry” before the public as a panacea designed to cure all the world’s ills. Success has often, as the vernacular has it, a tendency to go to one’s head. Our achievements in the past half century have done just this to a number of well-meaning, though not too critical, enthusiasts. Leaving “glory to God in the highest” more or less to the ministrations of the clergy, they asserted that it was up to “psychiatry” to set up a machinery for promoting “peace on earth and good will toward men.” Preparation for “world citizenship” was the declared motto of the 1948 Mental Hygiene Congress in London; cells (or something of the sort) were established in every psychiatric center worth its salt, beautiful sentiments were mouthed and munched and ruminated and codified, and indignant high priests branded those who did not share their pontifical zeal as nonconforming, cold-blooded, hard-hearted kill-joys. The results of all this bustle are well known to everybody; to quote Horace: “The mountains are in labor, and a ridiculous mouse will be born.” It is astounding, in retrospect, how few of us had the courage to stand up and try to restore the lost perspective.

The main difficulty seems to lie in the fact that the rightly heightened interest in matters that are not primarily somatic has, despite all protestations, led in some circles to a crowding out of the medical emphasis—medical in a sense broad enough to include the totality of the individual in his setting and sufficiently circumscribed to remind us at all times that we are physicians. As physicians, as medical scientists, we have obligations toward our patients and toward the data of factual observation. In a relatively young science such as ours, it is not easy to live up patiently to the second obligation. Theories rush in to fill the gaps in secured knowledge. Theories are helpful and stimulating and may lead to the discovery of new facts but they are decidedly not to be mistaken for the facts themselves. If they are, there is no limit to

the areas over which one can roam with unbridled abandon. Once someone has made up his mind that only the rooming-in program can save our civilization from complete collapse, he has, as was shown in a recently published book, no compunction in condemning obstetricians as sadistic ogres if they do not hasten to rebuild all lying-in hospitals. Once a person has become convinced of the illogicalness of the unconscious, there is nothing to keep him from running wild in irrational speculations. Once someone has resolved that the holy trinity of the clinical team is indispensable, every other mode of procedure must impress him as inadequate. All such assumptions and inferences are pronounced more or less vociferously as emanating from "psychiatry."

We have perhaps been much too tolerant and "permissive" with regard to all the claims and generalizations and grandiloquent promises purported to stem from "psychiatry." Is it a wonder, under the circumstances, that many nonmedical people feel qualified to do what they have been made to believe is our work?

There are refreshing signs that indicate that a change is in the offing; that Adolf Meyer, who was a physician first, last, and always, has not lived and taught in vain; that psychiatry, which some of its practitioners have allowed to stray far from its medical base, is not in danger of getting out of hand; that the humble, earnest workers in the field can get off the sinners' bench to which they have been sent by their world-reforming, fantasy-loving confreres as unimaginative, narrow-minded, "superficial" resisters of progress.

A recent decision of the American Board of Psychiatry and Neurology has gone a long way toward the official acknowledgement of psychiatry as a medical concern. The statement reads as follows:

After July 1, 1954, training credit for work in the field of child psychiatry may be gained only by participation in a hospital residency training program that is regularly approved. After that date, all independent training approval of psychiatric clinics for children is discontinued.

Some of our colleagues abroad have made a special point of pleading for greater sobriety and self-scrutiny. John F. Williams, of

Melbourne, Australia,¹ felt the need for discussing the limitations of pediatric psychiatry. He called for a dispassionate examination of current clichés that are often taught as articles of faith.

P. K. McCowan, in his 1951 presidential address before the Royal Medico-Psychological Association,² deplored the fact that the mental hygiene movement "tends to be brought into disrepute by those uncritical enthusiasts who give the impression that they have the key to a utopia from which war is banished, crime a thing of the past, and mental illness unknown outside textbooks." He expressed the hope that "progress in our specialty, in the future as in the past, will come mainly from the efforts of those actually engaged in the practice of psychiatry, and in research into its *special* problems."

Desmond Curran, in his 1952 presidential address before the Section of Psychiatry of the Royal Society of Medicine,³ criticized openly the notion that the sphere of our specialty includes world reform. He called for the evaluation of therapeutic results in place of too exclusive concern with psychopathological interpretation. He said: "I believe it is thoroughly bad mental hygiene and thoroughly bad psychotherapy to encourage the public or the patient to expect the probability of a transformation scene from psychotherapy or analysis." He spoke out against "the undesirable implications of psychiatric attempts at dominance in the social fields of politics, criminal responsibility, and employment—attempts that . . . are promoted by a sales technique that leads the public to unwarranted expectations of what we can give."

We have quite a bit to give—and quite a bit to learn—as psychiatric physicians, without intended or unintended self-inflation. If psychiatry goes beyond the boundaries of a medical specialty, it is apt to lose its identity—its very *raison d'être*—in a mist of glib eloquence, unchecked wish thinking, and unrealistic onslaught on Quixotian windmills.

¹ Williams, J. F. *Paediatric Psychiatry: Its Scope and Limitations*. Med. J. of Austral., 2: 76, 1951.

² McCowan, P. K. "Whither Psychiatry?" J. Ment. Sci., 98: 1, 1952.

³ Curran, D. "Psychiatry Ltd." Ibid., 98: 373, 1952.

Dr. Curran said in his address: "You may recall that in *The Importance of Being Earnest* Gwendolen says to Cecily: 'On an occasion of this kind it becomes more than a moral duty to speak one's mind. It becomes a pleasure.' And Cecily replies: 'This is no

time to wear the shallow mask of manners. When I see a spade, I call it a spade.' Fortified by this precedent, when I see bosh, I call it bosh."

Vivant sequentes!

L. K.

REPORT OF BOARD OF TELLERS, MAY 6, 1953

Symbolism:

(N) stands for candidates submitted by the Nominating Committee.

(P) stands for candidates submitted by petition as prescribed by the Constitution and By-Laws.

Office	Candidate	Address of Candidate	Vote
President-Elect	Arthur P. Noyes (N)	Norristown, Pa.	3,651
Secretary	R. Finley Gayle, Jr. (N)	Richmond, Va.	3,627
Treasurer	Howard W. Potter (N)	Brooklyn, N. Y.	3,628
Councillors (3 elected): ¹			
	S. Spafford Ackerly (N)	Louisville, Ky.	3,338
	Maurice Levine (N)	Cincinnati, Ohio	2,958
	Theodore Robie (P)	E. Orange, N. J.	1,770
	Paul L. Schroeder (N)	Atlanta, Ga.	2,763
Auditor	Arthur Milsap Gee (N)	Essondale, B. C.	3,396
Total ballots returned = 3,718			
Minus 19 voided = 3,699			

This is to certify that this is a complete tally of the mail ballot on Officers and Council.

C. N. BAGANZ, M. D.

Chairman, Board of Tellers.

¹ D. Ewen Cameron, Montreal, Que., Canada, retiring President, becomes a member of Council by constitutional requirement, Article IV, Sec. 1.

NEWS AND NOTES

LINDEMAN MEMORIAL.—To preserve the philosophy and values of the late Dr. Eduard C. Lindeman in education for social work and in our society, the New York School of Social Work, Columbia University, will establish a permanent "Eduard C. Lindeman Professorial Chair." Dr. Lindeman, who died April 13 in his 68th year, had been a professor at the School for 26 years. His unique career paralleled the growth of the adult education movement, of which he is regarded as its inspiring leader.

Dr. Lindeman joined the staff of the New York School of Social Work in 1924 and retired in 1950. In 1949 he was invited to India, where he served as visiting professor at the University of Delhi. He served as a member of the National Committee of the White House Conference on Children and Youth. He had been elected President of the National Conference of Social Work for 1953.

Plans for the Professorial Chair were announced at a special tribute meeting at The New York School of Social Work. An international effort will be made to obtain \$500,000 by "Lindeman Friendship Groups" to be formed in more than 16 cities throughout the United States and abroad.

DR. VESTERGAARD APPOINTED TO ROCKLAND RESEARCH PROJECT.—From the office of the Commissioner of Mental Hygiene, State of New York, Dr. Newton Bigelow, comes news of the appointment of Dr. Bjorn Vestergaard, Danish psychiatrist, to the staff of a special research project at Rockland State Hospital. His research work will be particularly concerned with the relationship of hormones to mental disease. The 32-year-old psychiatrist assumed his new position upon his arrival from Denmark May 4, 1953.

Dr. Vestergaard comes to America with a notable record in clinical psychiatry and biochemical research in his native Denmark. Since October 1949, he has served as director of biochemical research at Sct. Hans Hospital Ved Roskilde, Denmark, where he conducted biochemical and endocrinological in-

vestigations on psychiatric patients. He is the author of scientific papers published both in Danish and English.

DR. BRILL HEADS UCLA MEDICAL UNIT.—A new coordinated program in mental hygiene sponsored by the Medical Center of the University of California at Los Angeles and the State Department of Mental Hygiene, and headed by Dr. Norman Q. Brill formerly of Washington, D. C., is now under way. Dr. Brill is serving as chairman of the department of psychiatry at the Medical Center. The program is divided into 2 parts: one having to do with undergraduate professional training and basic research, and the other with postgraduate professional training, study of the problems of inpatients and outpatients, pilot studies for institutional application, and clinical research.

During the latter part of World War II Dr. Brill became deputy chief of the neuropsychiatry division of the Army Surgeon General's Office. He later served as head of the department of neurology at the Georgetown University Medical School.

DR. ROSENBAUM ON MISSION TO ISRAEL.—Dr. Milton Rosenbaum, professor of psychiatry in the University of Cincinnati, took up temporary duties recently as the first visiting professor of psychiatry at the Hebrew University—Hadassah Medical School in Jerusalem. He will assist in the establishment of a new department of psychiatry at Israel's only medical college. This special assignment was made possible by a \$150,000 grant to the medical school from the Julius and Marie Schneider Memorial Fund for Neuropsychiatry.

DR. ROBERT SELIGER.—The death of Dr. Robert V. Seliger of Baltimore occurred April 24, 1953. He was only 52 years old. Cerebral thrombosis was the cause of death.

Dr. Seliger was well known throughout the country especially through his studies and publications on alcoholism. A native of New York, he graduated in arts from the

University of Maryland and in medicine from Fordham University. For the past 15 years he had been on the staff of the Johns Hopkins School of Medicine.

Dr. Seliger was chief psychiatrist of the Neuropsychiatric Institute of Baltimore and executive director of the National Committee on Alcohol Hygiene. One of his best known books is "Alcoholics Are Sick People."

DR. JOSEPH L. FETTERMAN.—Dr. Victor M. Victoroff has kindly supplied the following information concerning Dr. Fetterman, director of the Fetterman Clinic, Cleveland, Ohio, who died April 12, 1953, of metastatic cancer.

Dr. Fetterman graduated from Adelbert College with a B. A. degree in 1918. He was awarded the M. D. degree from Western Reserve University College of Medicine in 1921. Later he added a Master's degree in medicine. He had a rotating internship at Mt. Sinai Hospital, Cleveland, Ohio, and was resident in surgery in medicine at that hospital. He became assistant neurologist at the outpatient department at Lakeside Hospital from 1923 to 1936. He was made assistant visiting neurologist in 1936 and kept this title until 1941. From that date until 1947, when he resigned to conserve his health and to establish the Fetterman Clinic, he held the title of Assistant Clinical Professor of Nervous and Mental Disease. His postgraduate study was taken with Paul Schilder and Joseph Gerstmann. He was the author of 3 books: "The Mind of the Injured Man," "Practical Lessons in Psychiatry," and a collection of epigrams called "The Spinal Column." He published over 70 professional articles in the areas of his interests: epilepsy, the relation between physical trauma and psychoneurosis, shock therapy, and problems in industrial and forensic psychiatry.

He belonged to no "school" of psychiatry but was in the vanguard of American psychiatrists who have evolved an eclectic point of view in dealing with problems in their neuropsychiatric practice.

DR. C. P. McCORD.—Dr. Clinton P. McCord of Albany died at his home on May 10 at the age of 72, after a long illness. Dr.

McCord was a graduate of the University of Pennsylvania Medical School and a member of the board of the Devereux Foundation, Devon, Pa. For 15 years he had served as director of health for the Albany public schools and as a member of the faculty of Albany Medical College. He was especially interested in criminology and social psychiatry and served as a consultant in neuropsychiatry and psychoanalysis.

INTERNATIONAL ASSOCIATION FOR CHILD PSYCHIATRY.—In connection with the Fifth International Congress on Mental Health, to be held in Toronto in August 1954, this Association will sponsor a two-day international institute on "The Emotional Problems of Children under Six." The Association invites clinical case studies of such children for presentation and intensive discussion by an international panel; these may be either cases that have been intensively treated or ones that present interesting problems in the course of thorough diagnostic studies. For full details write to Dr. A. Z. Barhash, secretary-general, International Association for Child Psychiatry, 186 Clinton Ave., Newark 5, N. J.

The Association also invites descriptions of current research projects dealing with the main topic. For further information about research papers write to Dr. Gerald Caplan, Harvard School of Public Health, 695 Huntington Ave., Boston 15, Mass.

DACTYLOLOGY FOR APHASICS.—Our attention is called to a new method of communication for the aphasic patient. This is a hand-talking chart devised by Dr. Hamilton Cameron from personal experience with aphasia. The method can be used in all speechless cases where the teaching of a complicated hand-sign language is impracticable or impossible. The chart is available without charge from Dr. Cameron, 601 West 110th St., New York 25, N. Y.

AMERICAN ASSOCIATION OF FRIENDS AND FAMILIES OF PSYCHIATRIC PATIENTS, INC.—This Association provides counsel and guidance in the areas of individual treatment, arrangements for suitable hospitalization; care of the incompetent's estate, readjust-

ment of released patients in the community, etc. The following officers were recently elected: president, Dr. George W. Henry; vice-president, Dr. Edward M. Shepard; executive vice-president, Dr. Maurice J. Shore; secretary-treasurer, Dr. Howard M. Newsburger. The offices of the Association are at 255 West 90th St., New York 24, N. Y.

AMERICAN PSYCHOSOMATIC SOCIETY.—At the annual meeting held on April 18, 1953, the following officers were elected: president, Dr. George L. Engel; president-elect, Dr. Lawrence S. Kubie; secretary-treasurer, Dr. Theodore Lidz; councilors, Drs. Robert A. Cleghorn, Jacob E. Finesinger, and Jurgen Ruesch.

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

The following were certified at San Francisco, April 30 and May 1, 1953.

PSYCHIATRY

- Abe, George Y., 322 E. First St., Los Angeles 12, Calif.
 Alston, Edwin Frederick, 2107 Van Ness Ave., Suite 207, San Francisco 9, Calif.
 Anderson, Harry J., 917 Larson Bldg., Yakima, Wash.
 Archibald, Herbert C., 1305 Franklin St., Oakland 12, Calif.
 Arnold, Dorothy Jean, 500 Newton Rd., Iowa City, Iowa.
 Aronson, Gerald Jay, Menninger Foundation, Topeka, Kans.
 Barker, Charles Paul, Pontiac State Hosp., Pontiac, Mich.
 Baskin, Thomas Grady, General Delivery, Annex III, Brooke Army Hosp., Fort Sam Houston, Tex.
 Beck, Aaron T., Valley Forge Army Hosp., Phoenixville, Pa.
 Behrman, James Milton, 2205 Churchill Way, Oklahoma City, Okla.
 Bennett, Eaton W., Brooke Army Hosp., Fort Sam Houston, Tex.
 Bergreen, Stanley W., 1100th Med. Gp., Bolling AFB Hosp., Washington, D. C.
 Bloch, Donald A., National Inst. Mental Health, Bethesda 14, Md.
 Brickman, Harry Russell, Depot Infirmary, Marine Corps Recruit Depot, San Diego 40, Calif.
 Brown, Raymond M., Psy. Dept., San Francisco City and County Hosp., San Francisco, Calif.
 Brunet, Emile J., Topeka State Hosp., Topeka, Kans.
 Burkett, John Wesley, Hq. 4th Infantry Div., APO 39, c/o PM, New York, N. Y.
 Cantor, Morton B., U. S. Army Hosp., 5022 ASU, Camp Carson, Colo.
 Christensen, Robert Lloyd, U. S. Army Hosp., Fort Leonard Wood, Mo.
 *Clausen, Roy Elwood, Jr., C-15, Fitzsimons Army Hosp., Denver, Colo.
 Cohen, Irvin H., U. S. Army Hosp., Fort Sill, Okla.
 Cohen, Richard Lawrence, 3882nd School Gp., M.O.Q., 213-B, Gunter AFB, Ala.
 Comly, Hunter Hall, 500 Newton Rd., Iowa City, Iowa.
 Cornell, Dale Duane, State of Idaho, Dept. Public Health, Box 640, Boise, Idaho.
 Counts, Robert M., Army Hosp., Indiantown Gap Military Reservation, Indiantown Gap, Pa.
 Crossfield, Ruth M., Glenside, 6 Parley Vale, Jamaica Plain Station, Boston 30, Mass.
 Dahl, Hartwig Adrian, Student Health Center, Univ. of Wash., Seattle 5, Wash.
 Davis, Alvin E., 1150 Glendon Ave., Los Angeles 24, Calif.
 DeAntonio, Carlo P., 3324 Sunset Blvd., Los Angeles 26, Calif.
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 Fowler, Marshall Lake, Jr., Gen. Del.-Annex 3, Brooke Army Hosp., Fort Sam Houston, Tex.
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 Gaitz, Charles Milton, 322 Medical Arts Bldg., Houston, Tex.
 Galioni, Elmer Francis, Stockton State Hosp., Stockton, Calif.
 Gamburg, Leo, 1630 Fifth Ave., Moline, Ill.
 Gilder, Rodman, Jr., 4536 Fairfield Dr., Bethesda 14, Md.
 Gonda, Thomas Andrew, 220 Gramercy Dr., San Mateo, Calif.
 Greenberg, Harold A., Sheppard and Enoch Pratt Hosp., Towson 4, Md.
 Hamburg, David A., Army Med. Serv. Graduate School, NP Division, Walter Reed Army Medical Center, Wash. 12, D. C.
 Hampe, Warren W., Jr., Norristown State Hosp., Norristown, Pa.
 Hanson, Karl Herman, U. S. Army Hosp., Camp Stoneman, Calif.
 Hargreaves, Robert P., Brooke Army Hosp., Fort Sam Houston, Tex.
 Harris, M. Robert, 360 N. Bedford Dr., Beverly Hills, Calif.
 Hausman, William, U. S. Army Hosp., West Point, N. Y.
 Herrold, Don W., 2520 Capitol Ave., Cheyenne, Wyo.
 Heuscher, Julius Ernest, 131 W. Main St., Los Gatos, Calif.
 Hiler, Emerson G., V. A. Hosp., Palo Alto, Calif.
 Hill, Gerald, 752 Book Bldg., Detroit 26, Mich.
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 Hoffing, Charles K., Box 14, USAF Hosp., Keesler AFB, Miss.
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 Kohrman, Robert, Michael Reese Hosp., 29th St. and Ellis Ave., Chicago 16, Ill.
 Kollar, Edward J., Jr., Office of Surgeon General, Hq., U. S. Air Force, Washington 25, D. C.
 Kupper, Herbert I., 13052 Evanston St., Los Angeles 49, Calif.
 Laderman, Peter, Mental Hygiene Consultation Serv., 7th Arm'd Div., Camp Roberts, Calif.
 Langdell, John Irving, 1756 14th Ave., San Francisco 22, Calif.
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 Liska, Edward S., 848 Thornhill Dr., Colma 25, Calif.
 *Litman, Robert E., 186 N. Canon Dr., Beverly Hills, Calif.
 Lund, J. Benjamin, 157 Taylor Ave., Ft. Snelling, St. Paul 11, Minn.
 Mackenzie, Thayer M., Johns Hopkins Hosp., 601 N. Broadway, Baltimore 5, Md.
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 Meadows, John W., Jr., Oregon State Hosp., Salem, Ore.
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* Denotes supplementary certification.

- Miller, Zane E., Vets. Adm. Hosp., 4435 Beacon Ave., Seattle, Wash.
- Mongillo, Barry B., 275 Wayland Ave., Providence 6, R. I.
- Mooney, Horace B., USAF Hosp., Travis AFB, Fairfield, Calif.
- Morrow, Thomas Francis, 3420 E. Douglas, Wichita, Kans.
- Mulholland, Richard F., Corozal Hospital, Diablo Heights, Canal Zone.
- Mundorf, George, 3204th Medical Grp., Eglin AFB, Fla.
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- Nelson, Herbert Leroy, Oregon State Hosp., Salem, Ore.
- Niblo, Grady, Jr., Topeka State Hosp., Topeka, Kans.
- North, Leon L., Jr., Norristown State Hosp., Norristown, Pa.
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- Pope, John Michael, Camarillo State Hosp., Camarillo, Calif.
- Pratum, Leif K., 307 Tower Bldg., Seattle 1, Wash.
- Price, Edwin F., 337 S. Beverly Dr., Beverly Hills, Calif.
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- Reiner, Herbert M., 25 E. Washington St., Chicago 2, Ill.
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- Thomas, Theodore J., Veterans Adm. Hosp., Tuscaloosa, Ala.
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- Visser, John Sargent, 1554 Campus Dr., Berkeley 8, Calif.
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NEUROLOGY

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* Denotes supplementary certification.

BOOK REVIEWS

SHOCK TREATMENTS, PSYCHOSURGERY, AND OTHER SOMATIC TREATMENTS IN PSYCHIATRY. SECOND REVISED AND ENLARGED EDITION. By *Lothar B. Kalinowsky, M.D., and Paul H. Hoch, M.D.* (New York: Grune and Stratton, 1952. Price: \$8.75.)

This is the second edition of the authors' earlier volume on shock treatments, considerably expanded after a lapse of 6 years, with a new chapter on psychosurgery added. The 3 major sections are concerned respectively with insulin shock treatment, convulsive therapy, and lobotomy or allied procedures. A short chapter gives brief attention to a variety of other physiological procedures; a concluding chapter sketches another miscellany of proposed explanations for the treatments and culminates with the statement, "At present, we can say only that we are treating empirically disorders whose etiology is unknown, with methods such as shock treatments whose action is also shrouded in mystery." The book contains an extensive bibliography of over a thousand titles, and has a useful index.

The authors have no special point of view to present and reveal a broad receptivity to all sorts of pertinent material in the literature. Since the book is frankly empirical in its approach, its usefulness and appeal depends on the authors' wide acquaintance with the literature, their long clinical experience, and the soundness of their clinical judgments. In all these respects, the book is eminently satisfactory and practicing psychiatrists can hardly dispense with it.

The authors have been closely identified with the work on convulsive treatment from the start, both here and abroad, and handle their material on this subject with skill and assurance. They give full consideration to all the variants and innovations, but are not easily persuaded. They are still partial to the original AC apparatus. The value of psychologic interest is recognized, but its role is not overplayed. They are sceptical of the value of barbiturate premedication. Routine use of curare is not recommended, and a large proportion of the fatalities in these normally safe treatments are attributed to its use. They believe hypertension should no longer be regarded as a contraindication. One could query a few of their clinical recommendations, but they are usually thoughtful and cannot be disregarded. On the whole, they are perhaps too friendly toward convulsive treatments. These must be very unpleasant to experience and for many physicians are still unpleasant to administer. One might wish that we had less crude tools to work with. The fear that patients so often develop is real, even if obscured by amnesia, and is probably due to the fact of overwhelming neural stimulation rather than the annoyance of the disorientation, as the authors suggest. There is a real impairment of mental efficiency, usually transient and slight, but sometimes prolonged

and perhaps even sometimes permanent. Although in the psychosurgery section the authors correctly insist on the reality of functional damage, even where formal psychometrics reveal no defect, they are inclined to accept the evidence of psychometric tests and microscopic studies to support the claim that convulsive treatments are innocuous. It should be added, however, that the authors consistently emphasize the basic importance of sound and carefully validated clinical observation.

The section on insulin treatment is fairly complete and few important contributions are overlooked, but the profusion of data is at times bewildering and some points of management already seem out of date. Many of the modifications and clinical manoeuvres recommended in the literature have proven useless, and it should now be possible to simplify the directions considerably. The most dangerous complication in insulin treatment, irreversible coma, should in my opinion be handled with blood transfusion in addition to the glucose and saline infusion recommended by the authors.

The psychosurgery section is competent and comprehensive. The authors certainly cannot be described as overenthusiastic toward the procedure, but believe it has an important place as a treatment of last resort. In the treatment of schizophrenia this means, in the authors' view, that "as soon as it becomes obvious that shock therapy has failed, psychosurgery should be considered." Does this imply that these procedures exhaust our present therapeutic armamentarium? It evidently does, for the remaining procedures outlined in the book are given only cursory attention: sleep treatment, hormones, histamine, and the various other therapies, which are scarcely more than named. The destruction of brain tissue by lobotomy can be avoided only if our treatment resources are improved and enlarged. One could have wished that some of the treatments, especially continuous sleep treatment, were accorded fuller consideration in a report of this sort.

A point of medical history should be clarified. Meduna deserves full credit for the first systematic elaboration of convulsive treatment. Meduna began his experimental animal work on November 23, 1933, and published nothing until later in 1934. Sakel's earlier reports, as the authors recognize (page 41), described the benefits of insulin convulsions and must be regarded as the first therapeutic advocacy of convulsions. Sakel's report, entitled *Erzeugung von schweren hypoglykämischen Shocks, eventuell mit Koma und epileptischen Anfällen durch hohe Insulindosen*, was presented at a meeting on November 3, 1933, and published on the 10th and 18th of that month. In spite of this his name is not mentioned in the history of convulsive treatment presented by the authors.

The book is an outstanding and authoritative contribution to the growing literature on physiological

treatment in psychiatry. Its weaknesses are in large part the weaknesses of our science. It is empirical. There is no framework of theory, no adequate basic physiology, no etiologic principles to guide the formulations or to pattern the scattered data. But the time is soon approaching (and may already be here) when a bolder attempt to organize these data and to formulate some general principles of etiology and treatment might yield a rich harvest of results.

JOSEPH WORTIS, M. D.,
Jewish Hospital,
Brooklyn, N. Y.

SOCIAL PSYCHOLOGY. By Solomon E. Asch. (New York: Prentice-Hall, Inc. 1952. Price: \$5.50.)

Thoughtfully, gently but firmly, Solomon E. Asch (professor of psychology at Swarthmore College) interweaves the tenets of the gestalt-derived situational perspective into this social psychology textbook. In format the 20 chapters are allocated under an Introduction and 4 sections: Organization in Psychological Events, Human Interaction, Social Needs, and Effects of Group Conditions on Judgments and Attitudes. Chapters are characteristically introduced by a delineation of contrasting doctrines that relate to the topic. Thus the chapter on "Doctrines of Man" begins with a brief but incisive description of the biological concept of man, the sociological approach to man, and the Freudian concept of man, while the chapter on "Social Interests" is introduced by counterpoising the instinctivist solution to the convergence of environmentalist and Freudian doctrines. These delineations of the assumptions, content, and implications of contrasting doctrines about human behavior constitute useful contributions in themselves and can be recommended as a source for a refreshing review by psychologists, sociologists, and psychiatrists.

More clearly and more frankly than most textbook writers, Professor Asch acknowledges the limitations of both knowledge and technique that characterize those disciplines that study human civilized behavior. In one of many trenchant passages he describes the current state of knowledge from psychology (pp. 24-25): "Modern psychology has often drawn, I suspect, a caricature rather than a portrait of man. As a result it has introduced a grave gap between itself and the knowledge of men that observation gives us and from which investigation must start. Those who are not psychologists (and psychologists when they are off duty) speak of such strange things as fair play, justice and injustice, even of dignity and the need for freedom. They act on the assumption that men are the kind of beings that have the capacity to understand, that they have a sense of responsibility and can distinguish right from wrong. Common sense realizes that men do not always or even most often act according to their best impulses, but it also acknowledges that these impulses are the necessary conditions for society. Yet not only are these ideas excluded from scientific discussion; the conceptual schemes with which psychology works today hardly leave room for them. We begin to discern a systematic partiality in cur-

rent psychological ideas. They speak of motives but they have no place for the joy of life; they describe action as the pursuit of one goal after another in an endless chain, but they forget the facts of planning and achievement, of wit and creation."

Professor Asch points out that such serious gaps in knowledge, and such one-sidedness in perspective, are frequently justified in the name of science and objectivity, but wonders if perhaps this is not a spurious objectivity and whether "the simplicity and apparent freedom from presuppositions may not hide a dogmatism all the more inflexible because it speaks in the name of science" (p. 25).

Throughout this tempered, insightful, and sensitively written text Professor Asch modestly but with consistent coherence elucidates his theme (p. 35): "In this work I shall try to defend the position that the facts of social behavior—such as those of group unity, leadership, and social organization—are as much facts about individuals as the perception of pitch and color."

For one who spent several years examining textbooks from the sister-discipline, sociology, in order to document a critique of the claims and emphasis, it was a refreshing experience to review Solomon Asch's *Social Psychology*. While some statements in this text might be questioned, such are few, and they are subordinate to the over-all moderation in claims. Not only as a text is this book recommended, but also as a source of a highly promising perspective from which to approach an understanding of human behavior in civilized society.

A. H. HOBBS, PH. D.,
University of Pennsylvania.

ORGANIZATION AND PATHOLOGY OF THOUGHT, SELECTED SOURCES. Translation and Commentary by David Rapaport. (New York: Columbia University Press, 1951.)

This unusual book must be discussed from several aspects: (1) as a compendium of important writings on thought of which many until now were inaccessible to most readers for biblio-technical reasons and because they had not been translated into English. The selection and translation alone of these papers makes a substantial contribution to psychology.

(2) In addition to the preparation of these papers, the author has joined a continuous commentary of footnotes to the original text. In these footnotes ideas are compared and extrapolated, and terminology explained and related to other homologous terminologies—that is, to propositions and constructs that deal with the same matter of experience but attempt to absorb it into different terms, or approach it by means of different theoretical schemata. Thus an extraordinarily complex system of cross-references has been created in the present volume. Admittedly, it leaves the reader's understanding blurred for some time. Once the intricate network of connections has been recognized from the point of the central issue—namely, that of a theory of thought and its disruptions, these guiding comments will be very helpful. One might put it that the first footnote will not become fully meaningful until after the last paragraph of the last paper has been read. Only

then does the full extent of the labor that must have gone into this organization become clear. For these footnotes were, so to speak, written by ear, with the argument of all the other papers (and a considerable volume of literature in addition) constantly in mind so that they could be universally compared and connected. The final effect of this method is a secondary unity of discourse that adds to each paper by placing it in a larger universe of which quite often the author may not have dreamed. All papers are seen in the pursuit of one common problem. From the point of view of Rapaport's encompassing organization one gains the impression that those investigations, dependent upon the conceptual tools and systemic inclinations of their time, were themselves functions of a trend that emerges only in retrospect.

(3) The selection of papers and the author's commentary also represent something of a history of ideas on thought. It is fragmentary only for the reason that other important writings that are more easily accessible to the professional reader have not been considered. "The papers of this volume are organized into five groups: Directed Thinking, Symbolism, Motivation of Thinking, Fantasy Thinking, and Pathology of Thinking." It is a safe guess that at least every second reader who has been interested in that field will have some regrets and some criticism. My own predilection would have been for the inclusion of some German epistemologic writing. I would have thought it especially wholesome for psychologists who incline to think that philosophers are exclusively and incorrigibly concerned with "metaphysics" rather than (as they quite frequently have been and are) with exactly the same problems that concern psychologists.

(4) Finally, the idea of marginalia—a running commentary that accompanies the argument—is in itself a notable rediscovery. It is probably the oldest method of transforming the unconscious sequence of incidents into a meaningful process. In the past its service has ranged from religious revelations to the equivocalities of the law. It is still being used in philosophy, but with the emancipation of the social sciences it has fallen into oblivion there. Thus, purely as a demonstration of method, this book should not be without effect. The fact is that psychologists have been rather helpless in dealing with the ideas that have accumulated in their field. Owing to the experimental tradition and generally to limitations of space, all the writing relevant to a problem can at best be abstracted in the briefest manner. In the present rigid pattern of scientific communication there is just no room for deriving common trends and a continuity in the approach to a problem. The scientist as a rule has no opportunity to survey a universe of discourse for the purpose of synthesis. He is expected to state his problem, his hypothesis, and the method he will use in testing it. He should have read the communications of others; but he is plainly barred from thinking about them publicly to the end that he may integrate many discrete propositions into a new and better one. It is a safe prediction that in this sense Rapaport's marginalia will provoke a good deal of criticism. One hopes

that they might also have some effect on the deadlock of communication in psychology.

(5) In a concluding chapter Rapaport sums up or "extract[s] . . . the concept of thought-processes which to me seems implicitly sketched in the foregoing papers. . . . This assembly is organized around the psychoanalytic theory of thinking." The statement that the author "extracted" the concluding chapter should not deceive us as to its real quality. Far more than a summary, it represents a thoughtful and scholarly essay in theory-building. It is a theory of thinking, and as such is a systematic integration of propositions that will have to be acknowledged and evaluated. It is a different question to appraise critically what has gone into this system. The conceptual foundation of this "assembly" is in the Drive-Energy—Tension-Reduction concept. Action arises in order to regain equilibrium; thinking from the memory traces left by cathexes. Consciousness follows as a cathexis of memory traces of gratification. Reviewing these propositions, for instance, one is reminded again that psychoanalysis is still bound to operate within the schematic limitations of some of its fundamental concepts. But should a theory of thinking commit itself to all the paradoxical assumptions that have to be made if a thermodynamic energy model is to be maintained? There Rapaport's concluding chapter may render a final service by pointing up, through its very comprehensiveness, where we shall have to think of better theoretical schemata for what is indeed the unchanging fruitfulness of the psychoanalytic approach. Many of its schemata, as in cathexis, belong to the physicalisms of the nineteenth century where Freud found them. The fundamental contribution of psychoanalysis, however, lies not in these models but in the quest for instincts and their vicissitudes (to use Freud's words) and for the cognitive functions of the ego in attempting to integrate its perception of physical and social reality into a reasonably secure, consistent, and satisfactory unity of conduct.

FREDERICK WYATT, Ph. D.,
University of Michigan.

FORENSIC PSYCHIATRY. By Henry A. Davidson,
M.D. (New York: Ronald Press, 1952.
Price: \$8.00.)

The preface to this book commences: "This manual has been written as a psychiatric-legal guide for physicians." Elsewhere (page 125) Dr. Davidson uses these words: "It is not the place of this book to suggest reforms in the law." These comments indicate clearly the character of the book, which is practical rather than theoretical, categorical rather than exploratory.

The text is devoted to a statement of the substantive law and legal procedures that are applicable to the problems encountered in forensic psychiatry. No other work is likely to provide so much in the way of practical assistance for the psychiatrist engaging in a court case. Physicians other than psychiatrists also will find it a useful text in forensic medicine. What the author has written about "the tactics of testimony" and such subjects as preparation for trial and courtroom technique applies not only to

psychiatry but to other aspects of clinical medicine.

Fewer than 50 pages (pages 3 to 48) in a total volume of 387 pages deal with the criminal aspects of forensic psychiatry. As a result, the author has space to describe adequately civil problems that occur so frequently in practice, problems such as psychiatric evaluation of personal injuries; mental illness in relation to marriage and divorce; testamentary capacity; malingering; contractual capacity. Adequate treatment of some of these civil problems in forensic psychiatry has resulted in a book that fills a real need. Most psychiatrists know the M'Naghten rules—probably fewer could state precisely the legal rules governing testamentary capacity.

It is a pleasure to find that Dr. Davidson in this textbook has preserved the lucid wit that makes for easy reading of his shorter articles and pleasant listening to his oral presentations.

The author is obviously aware of the legal differences in various legal jurisdictions. For example, in discussing legal commitment, he states (page 196), "...there is considerable state-by-state variation." There is a minor lapse in the only reference in the book to Canada (page 197): "The situation in Canada appears to be less favorable to the mental hospital patient." Canada consists of 10 provinces that exhibit a province-by-province variation comparable to the state-by-state variation in the United States.

This book belongs high on any list of recommended reading in the field of forensic psychiatry.

K. G. GRAY, M. D.,
University of Toronto.

CHANGES IN CIRCULATION THROUGH THE ANTERIOR CEREBRAL ARTERY: A CLINICO-ANGIOGRAPHIC STUDY. By *Sven Ethelberg*. (*Acta Psychiatrica et Neurologica, Supplementum No. 75, 1951.*)

This paper represents a Doctor's thesis from the University of Copenhagen. The author deserves credit for compiling and discussing such an extensive literature. The criticism may be made that many of the basic concepts, familiar to those working in this field, are discussed in too great detail.

The paper is divided into 2 sections: the first deals with normal and abnormal angiography, the second with clinical investigations.

The anatomy of the A.C.A. and its branches is given in greater detail than in the common textbooks of neuroanatomy. One branch is of special interest, namely the recurrent artery of Heubner, which supplies parts of the internal capsule, nucleus caudatus, putamen, and globus pallidus, which are usually looked at as domain of the middle cerebral artery only.

Technical difficulties encountered in angiography of the A.C.A. are discussed. The anterior communicating is the only branch that cannot be visualized because of its anatomical position. Collateral circula-

tion is maintained through the main basal vessels except in case of obstruction of the middle cerebral artery, when circulation is carried through the small peripheral vessels.

The following pathological conditions lead to changes in the A.C.A.: (1.) occlusion of the artery due to atheromatous changes, syphilitic arteritis, and obliterating thrombangitis, (2.) arterial aneurism, (3.) atrio-venous aneurism, (4.) intracranial meningioma. (This is the only tumor that affects the A.C.A. exclusively.)

The mechanism of cellular destruction by meningiomas considered by the author consists in shunting the bloodstream into the highly vascularized tumor and thus depriving normal tissue of its blood supply. For this theory no experimental proof was presented. This seems unconvincing.

The last chapter of the first division deals with theoretical speculations on the effect of hypoxemia and anoxemia on nerve cells.

The chapter on mental changes associated with involvement of the A.C.A. is lacking in regards detailed information from the clinical psychiatric point of view.

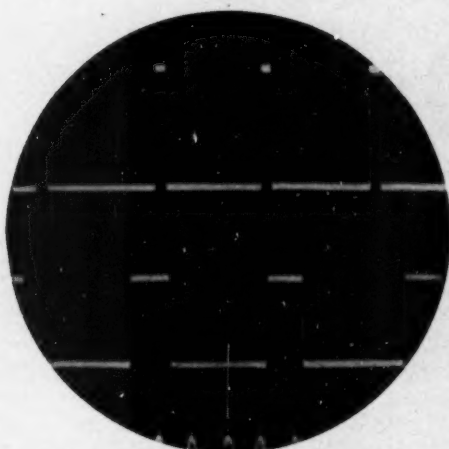
In cases with sudden interference with circulation through the A.C.A. the author assumes that unconsciousness is connected with the resulting abnormal discharge of nerve cells in the area of vascular damage. This hypothesis is based on a paper by Walker and co-workers, who found abnormal discharges of high electrical potentials in encephalographic studies following cranial trauma associated with unconsciousness. True aphasia was never observed following occlusion of the A.C.A. Dysarthria, however, does occur. Other neurological findings are as follows: hemiplegias with flaccidity or rigidity, contralateral crural monoplegia, complete contralateral hemiplegia, and sometimes forced grasping. Other clinical findings noted in cases of A.C.A. occlusion were intention tremor and dysmetria, disturbances of equilibrium without vertigo, and positive Romberg. Sensory symptoms consisted rather in paresthesias than in loss of sensation. Autonomic changes attributed to lesions in the premotor area 6 and 4 consisted in the rise and fall of blood pressure, cyanosis of the limbs, dystrophic changes of the skin, and bladder disturbances.

In a final chapter the author discusses diagnosis and prognosis. The prognosis depends on the cause of the circulatory impairment. Slowly developing occlusions have a better prognosis than the acute ones. The most serious complication is rupturing and thrombosis of an aneurism. The surgical treatment consists of ligation of the afferent artery or in complete removal of the aneurism. In some cases post-operative seizures were reported that persisted for years. Fifty-five case histories are given in the appendix.

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1. G. Hirschfeld, *Diseases of the Nervous System* 12: 3-7 (1951)
2. George Ulett, *Proc. of the Electroshock Research Assn., Printed in Confinia Neurologica* 12: 298-305 (1952)

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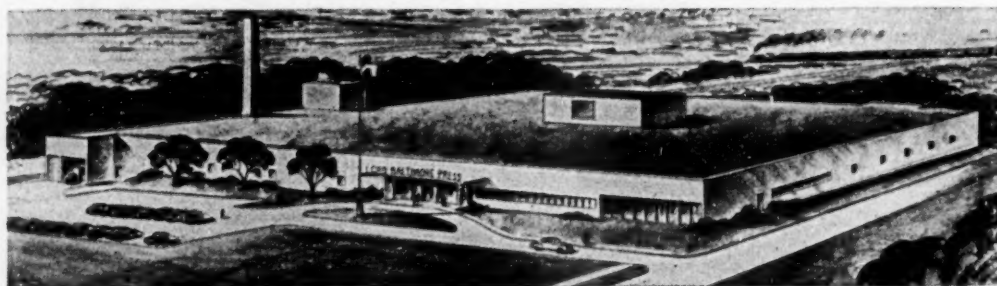
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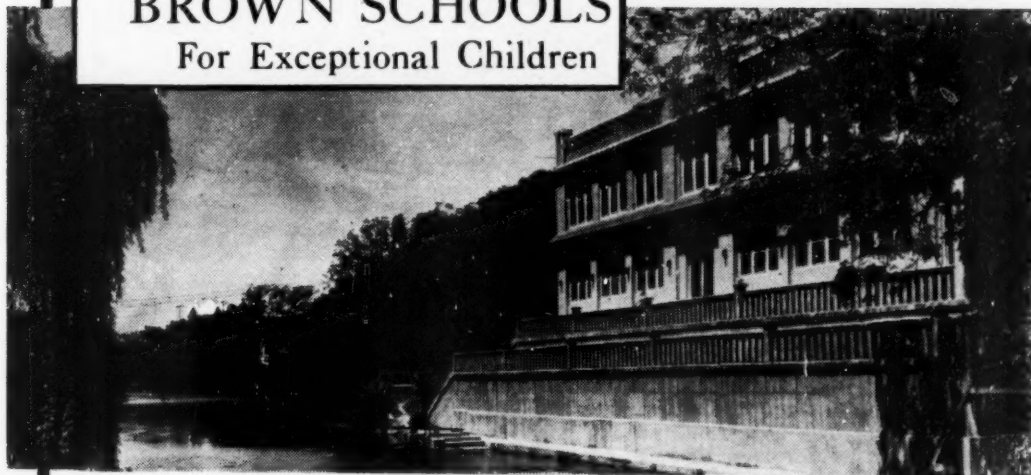
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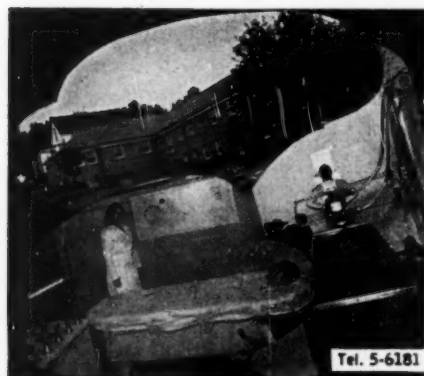
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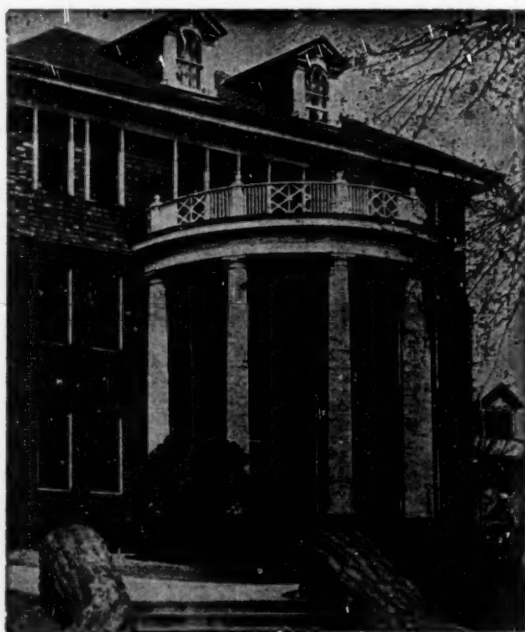
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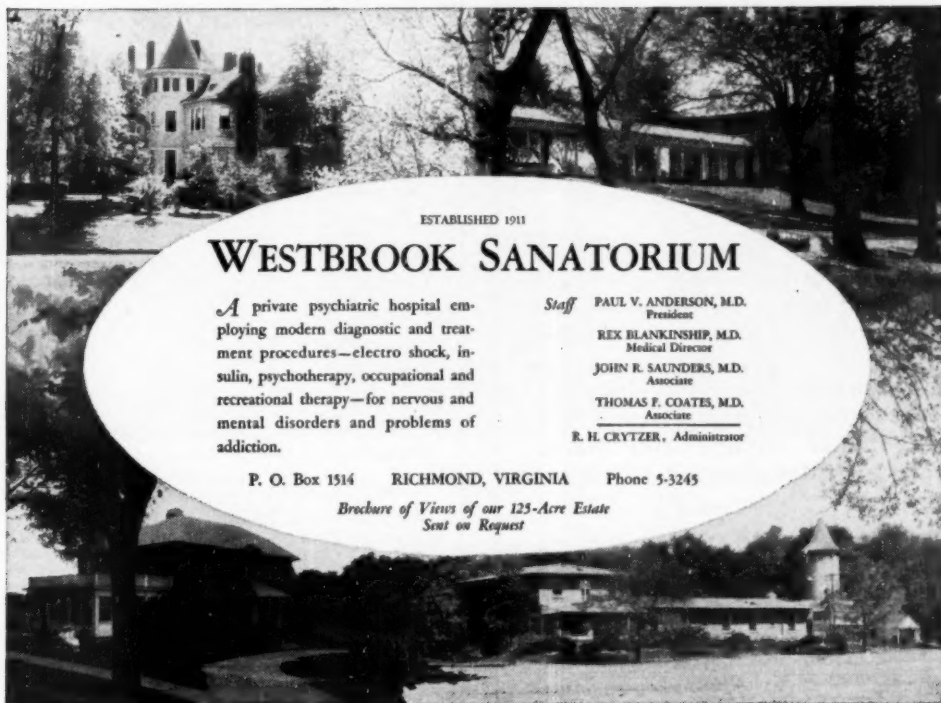
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